

071329 NOV 10 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 3093 EST  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THEODORE (NMY) AHMUTY SR			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 07, 1987			2b. HOUR 618 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Field Maintenance MD State Roads		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY AA		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 321 Nevada Avenue 21113		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Ahmuty			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Pratt			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 215-18-6866	
17. INFORMANT Evelyn P. Ahmuty, Same as 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/27/87</u> to <u>11/7/87</u> , that (I) (we) last saw the deceased alive on <u>11/7/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Recep Erol, M.D.</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RECEP EROL, M.D.			22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 104 GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 9, 87			23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA MD		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md			ADDRESS NOV 9 1987			DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the funeral papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other event, the medical examiner must be notified at once.

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THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

CHICAGO, ILL.

TO THE DIRECTOR, NATIONAL BUREAU OF STANDARDS

WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dorothy A Annis</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 29, 1987</b>				
2b. HOUR <b>12:10 P.M.</b>									
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 30, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>	
13a. STATE <b>Pennsylvania</b>		13b. COUNTY <b>Centre</b>		13c. CITY OR TOWN <b>Munson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>RD 2 Box 459, 99999</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert --- Heffler</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Belle --- Lucas</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>195-24-5825</b>		17. INFORMANT ADDRESS <b>Lois Johnson, RD 2, Box 459, Munson, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/15/85</b> to <b>11/29/87</b> , that (I) (we) last saw the deceased alive on <b>11/18/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Hilary T. O'Herlihy</b>						DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-30-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hilary T. O'Herlihy, M.D.</b>						22e. ADDRESS <b>325 Hospital Drive, Glen Burnie, MD. 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/2/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Messiah Baptist Ch. Cem., Kylertown, Clearfield, PA.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John T. ...</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 30935  
REG. NO.

069233 OCT 21 1987

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
		Alice Lee Armiger		Female		White		May 14, 1900		87 YRS		Maryland		USA				Anne Arundel Co. MD		Crownsville		Fairfield Arundel Nursing Center		Chief Operator (Ret)		C&P Telephone	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE																			
Maryland		Anne Arundel		Severn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1443 Virginia Avenue 21144																			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter)		ADDRESS																	
Mahlon Disney		Harriet M. Wigley		No		220.03.0520		Mrs. Elizabeth M. Newbill		Same as #13																	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		bilateral acute pneumonia		5 days																					
		DUE TO, OR AS A CONSEQUENCE OF		Alzheimer's Disease		6 years																					
		DUE TO, OR AS A CONSEQUENCE OF		Potentia basal artery insufficiency		4 years																					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		none																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																					
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/17 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Dr. Randall McLaughlin MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 10/19/87																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																									
Dr. Randall McLaughlin		3708 Mountain Road Pasadena, Maryland 21122																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE																					
Burial		Oct 21, 1987		Cedar Hill Cemetery		Brooklyn Park A A Co. Maryland																					
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE																							
Singleton Funeral Home Glen Burnie, Maryland		OCT 20 1987		John Davidson																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, page 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87 REG. NO. 30936							
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 74 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d STREET ADDRESS / ZIP CODE			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17 INFORMANT ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Transitional cell Ca Bladder				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)							
		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>87</u> , to <u>11/24/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Nov</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				DEGREE				22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (TYPE)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME		24 ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 30937  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT E ASHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 29 1987</b>			2b. HOUR <b>245 P.M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 19 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (CITY OR TOWN) <b>AAE MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>					
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT BUSINESS ADDRESS; GIVE STREET ADDRESS) <b>A.A. GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES MAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BEVERAGE</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>AA.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3032 ARUNDEL ON BAY RD 21403</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD E. ASHER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHARLOTTE CRUTCHLEY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>230 16 8556</b>		17. INFORMANT ADDRESS <b>CATHERINE ASHER #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>86</b> , to _____, 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>NOV 29</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John D Jackson</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11-30-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN D JACKSON</b>				22e. ADDRESS <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (CITY) <b>BURIAL</b>			23b. DATE <b>12/3/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOPKINS CHAPEL CEM.</b>		23d. LOCATION (CITY OR TOWN) COUNTY <b>EDgewater AA. MD.</b>				
24. FUNERAL DIRECTOR NAME <b>TAYLOR FUNERAL CHAPEL</b>				ADDRESS <b>ANNAPOLIS MD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 03 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Handwritten Signature</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified of one.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 0 9 3 8

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR		
MARTHA H. BARKER						11-18-87					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
FEMALE	White	7 14 54	33 YRS.			11-18-87			10:36a		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.			USA						Anne Arundel County MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			North Arundel Hospital			Housewife			Household		
13a. STATE											
Md.											
13b. CITY OR TOWN											
A. Arundel											
13c. CITY OR TOWN											
Gambrills											
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
13e. STREET ADDRESS											
2291 Four Seasons Dr. 21054											
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Skelton C. Higgins						Florence Thornton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No						218525271			John Barker same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11-18-87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
								driver of an auto/truck impact			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
				street				Waugh Chapel Road Anne Arundel Co., Maryland			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 11-19-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Margarita A. Korell, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				11/23/87		Meadowridge Mem. Pk.				Dorsey A. Arundel Md.	
24. FUNERAL DIRECTOR NAME						25. REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
Hardesty Funeral Home, Annapolis, Md.						NOV 20 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1001. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. MAIL PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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HABIT MOTION & CO

NOV 30 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30939

1. DECEASED NAME (TYPE OR PRINT)		FIRST EVELYN		MIDDLE M.		LAST BARRETT		2a. DATE OF DEATH		MONTH 11		DAY 18		YEAR 87		2b. HOUR 11:25AM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 3 DAY 16 YEAR 31				6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.													
10. CITY OR TOWN OF DEATH Arnold		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 815 Bradford Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY --									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 815 BRADFORD AVENUE 21012													
14. FATHER'S NAME FIRST WILLIAM MIDDLE H. LAST REYNOLDS						15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE G. LAST SNYDER															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-28-3998				17. INFORMANT ADDRESS 21012 JAMES R. BARRETT, SR. 815 BRADFORD AVE.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension, ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatoid arthritis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Status Colostomy</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
MEDICAL CERTIFICATION																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>1986</u> to <u>10/21</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>Mustofa Oz</u>												DEGREE		22c. DATE SIGNED 11/18/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mustofa Oz												22e. ADDRESS Severna Park 605 Baltimore Annapolis Blvd.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 11/23/87		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND											
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.												ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR NOV 20 1987				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Baker</u>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8730940  
REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Nellie - E. Helen				Bass		November 30, 1987		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		December 15 1897		89		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
England		U.S.A.				Anne Arundel				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Severna Park		321 Gordon Ave.		Homemaker		Own Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Anne Arundel		Severna Park				321 Gordon Ave.		21146	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Smith				Emma Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No				N/A		213.54.0218		(Grand Daughter-in-law) Barbara E. Foraker Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK											
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)											
21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>87</u> , to <u>Present</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.											
22b. SIGNATURE <u>Victor M. Plavner</u> M.D. DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22c. DATE SIGNED <u>11/30/87</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Victor M. Plavner, M.D.</u>											
22e. ADDRESS <u>1521 Ritchie Hwy., Arnold, Md. 21012</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)											
23b. DATE <u>Dec. 3, 1987</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk</u>											
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie A.A. Co. Maryland</u>											
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home</u> ADDRESS <u>Glen Burnie, Maryland</u>											
25a. DATE REC'D. BY REGISTRAR <u>DEC 01 1987</u>											
25b. REGISTRAR'S SIGNATURE											

REPORT NOTED 3/20/51



CONFIDENTIAL

1/2/51

X

1/2/51

69963 OCT 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 30941

1. DECEASED NAME (TYPE OR PRINT) <i>Catherine A. Bennett</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 23 87</i>			2b. HOUR M <i>10</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 7, 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>0 0 0 0</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Vienna, VA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>523 Manor Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest C. Hall</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nannie Gibson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-09-2895</i>			17. INFORMANT ADDRESS <i>Joan B. Clark, P.O. Box 216, Mayo, MD 21106</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio-pulmonary failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Carcinoma of the left breast - post-operative</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <i>Aug 15, 1987</i> 19____, to <i>10-23-87</i> 19____, that (I) (we) last saw the deceased alive on <i>10-16-87</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Fred C. Cristofari MD</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/24/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Fred C. Cristofari MD</i>						22e. ADDRESS <i>648 Deale Rd Deale, Md 20751</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Oct. 26, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie AA MD</i>			
24. FUNERAL DIRECTOR NAME <i>James S. Kirkley, Glen Burnie, MD</i>						25a. DATE REC'D. BY REGISTRAR <i>OCT 26 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (PRINT) Elmer		11-3-87				M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Galesville Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD			
10. CITY OR TOWN OF DEATH Galesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 4852 Church Lane 20765				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Seafood	
13a. STATE Md		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Galesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4852 Church Lane 20765	
14. FATHER'S NAME Charles Christian Benning		15. MOTHER'S MAIDEN NAME Ruth Evelyn Deale							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-05-0058		17. INFORMANT ADDRESS Margaret Gaug Galesville, Md 20765					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic adenocarcinoma colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minute</u> <u>3 weeks</u> <u>2 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> 19 <u>85</u> to <u>11/3</u> 19 <u>87</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>10/27</u> 19 <u>87</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.									
22b. SIGNATURE <u>G. Neiller</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>11/5/87</u>			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. Neiller</u>		22g. ADDRESS <u>134 Owensville Road West River</u>							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 11-6-87		23c. NAME OF CEMETERY OR CREMATORY Quaker Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Galesville A.A. Md			
24. FUNERAL DIRECTOR T.A. Hardesty Annapolis Md. 21401				25a. DATE REC'D. BY REGISTRAR NOV 6 1987		25b. REGISTRAR'S SIGNATURE <u>David R. Randle</u>			

BP

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ITEM 18a, 22a Film G634 12-30-87 dw

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0943

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Michael Boyd Bibb Jr.								ESTIMATED		11		1		1987		M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Mar. 27, 1970		17 YRS.						11		1		1987		1:36 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia		USA				Anne Arundel County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Annapolis		Anne Arundel General Hospital		Student		Education											
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Virginia		Stafford		Stafford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		221 Tacketts Mill Rd.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Michael B. Bibb, Sr.		Linda Byrd															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		227-06-6238		Michael B. Bibb, Sr.		Stafford, VA											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a).		Seizure disorder															
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
Anomalous origin of coronary arteries																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Mario F. Golle, jr., M.D.		Assistant		11/2/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Mario F. Golle, jr., M.D.		111 Penn St		Balto, MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		11/4/1987		Stafford Memorial Park		Stafford, Virginia											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Jr. David Mullins		Mullins Funeral Service Fredericksburg, VA		JV 10 1987		Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OSCAR B E. BLAIR, Jr.					2a DATE OF DEATH MONTH DAY YEAR 11 15 87		2b HOUR 6 A M		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 22 24		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62		IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Miss		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE Arundel MD			
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. Gen. Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Disabled		12b. KIND OF BUSINESS OR INDUSTRY Con't. Can Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE M.D. 13b. COUNTY A.A. 13c. CITY OR TOWN Glen Burnie					13d. IN-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 123 Warwicksire/21061		
14 FATHER'S NAME FIRST MIDDLE LAST OSCAR E. BLAIR, Sr					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Benning				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/>					16b. SOCIAL SECURITY NO. 030000000		17 INFORMANT ADDRESS Adelia G. Blair, Same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic liver cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer in unknown place</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepato-renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute Tubular Necrosis in kidneys</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I, this hospital) attended the deceased from <u>11/04</u> , 19 <u>87</u> , to <u>11/15</u> , 19 <u>87</u> , that (I/we) last saw the deceased alive on <u>11/15</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (Unless stated did not view the body after death.)									
22b. SIGNATURE <u>Alex Torres</u> DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 11/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alex Torres					22e. ADDRESS South Baltimore Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD			
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD					25a. DATE RECEIVED BY REGISTRAR NOV 17 1987				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the placental certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or resuscitation. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 30945 REG. NO.			
1. DECEASED NAME (Type or Print)		FIRST MIDDLE LAST HERMAN BLUMENTHAL		2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 18, 1987		2b. HOUR 10:45P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 25, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAPOLIS CONVALESCENT HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESIDENT		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY C. BLUMENTHAL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE LEIBOWITZ		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-16-4856	
17a. STREET ADDRESS (21208) 7211 PARK HTS. AVE., APT. 204		17b. STREET ADDRESS (21208) 7211 PARK HTS. AVE., APT. 204		17c. STREET ADDRESS (21208) 7211 PARK HTS. AVE., APT. 204		17d. STREET ADDRESS (21208) 7211 PARK HTS. AVE., APT. 204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dementia of the Alzheimer Type DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Atrial Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Poor nutrition, decubiti, Chronic Heart Failure		20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b. PART I OR PART 2)		22a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. certify that (I) (this hospital) attended the deceased from 11-16-87 to Present 19-87, that (I) have lost saw the deceased alive on 11-16-87, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE PETER EVERKOW		22c. DEGREE DEGREE		22d. DATE SIGNED 11-19-87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/20/87		23c. NAME OF CEMETERY OR CREMATORY HAR SINAI CONG. CEM		23d. LOCATION OWINGS MILLS BALTO. MD STATE	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215		25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30946

1- FOR  
STATE  
REGISTRAR

1. BASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-11 1987		2b. HOUR M a. M	
Walter		(NMN)				Borowski Jr.					
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 04 03 49		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 11-11 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 170 north of Dorsey Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Co. Investigator		12b. KIND OF BUSINESS OR INDUSTRY WMTA			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8130 Telegraph Road		21144	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Borowski, SR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Schwartz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Wilhelmena Borowski Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8120 (b) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:40 AM 11-11 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver ejected in auto/auto impact					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 170 north of Dorsey Rd., Anne Arundel Co., Maryland					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margarita A. Korell				M.D. Assistant				DATE SIGNED 11-12-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE:		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation				11-16-87		Security Process		Baltimore, Balto. MD			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MacNabb Funeral Home, Catonsville, MD				NOV 17 1987		James Gordon-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BRACKET IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



015555 JUN 1965



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30947	
1. FOR STATE REGISTRAR											
1a. DECEASED NAME (FIRST MIDDLE LAST) 1887 Roland Boteler, Sr.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 11 11 1987	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 13 23 64 RS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 11 1987		2d. HOUR M 1945 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ferndale, Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA MD.	
10. CITY OR TOWN OF DEATH Brooklyn Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 221 Southerly Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Machinist		12b. KIND OF BUSINESS OR INDUSTRY Koppers	
13a. STATE Md.				13b. COUNTY A.A.		13c. CITY OR TOWN Brooklyn Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 221 Southerly Rd. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Brantley Boteler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lessie Dorney				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 216-16-2900				17. INFORMANT ADDRESS Escondido, CA 92025				17. INFORMANT Roland Boteler, Jr., 1481 Autumn Woods Pl			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>ASCD</u> (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CVA</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>William P. Jones</u>				TITLE (SPECIFY) M.D. DEPUTY				DATE SIGNED 4/13/87			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Ct. 21035							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD			
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE <u>John D. Anderson</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30948 EST

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH REED BOYER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 13, 1987</b>			2b. HOUR <b>1140 PM</b>					
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 23, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>912 Reece Road 21144</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry E. Krebs</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie L. Reed</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (son) <b>Mr. David C. Boyer</b>		ADDRESS <b>8 Wilson Blvd. S.W. Glen Burnie, Md. 21061</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Metastasis to liver, severe ch. obs lung disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>B. K. Khandeewald</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/14/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. K. Khandeewald</b>						22e. ADDRESS <b>7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 17, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A. Maryland</b>			
24. FUNERAL DIRECTOR'S NAME <b>A. J. Hopkins</b>						1 Second Ave. S. W. Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Tracy R. ...</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon pages (Pages 1 and 2) and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 87 0949							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
SUSANNE THERESA BRAUN						11-11-87		10:05A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		Caucasion		June 19, 1915		72 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Crofton		Crofton Convalescent Center				Bookkeeper		Priv. Comp. 21146	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland		A.A. Co.		Severna Park				18 Madary RD Severna Pk	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
John Braun Sr.					Katherine Braun				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		212-09-3383		Joseph Braun (Same as above # 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Respiratory Arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 6 19 87, to Nov 11 19 87, that (I) (we) last saw the deceased alive or alive (If deceased did not view the body after death).									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Paul S. Rhodes MD								11/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Paul S. Rhodes MD		1667 Crofton Center Crofton							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		11-13-87		Cedar Hill		Brooklyn, AA. MD			
24. FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Jim ROBERT S. BARRANGO				SEVERNA PARK, MD. 21146		NOV 12 1987		Julia Davidson-Randall	

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ROBERT S. BARRING  
BEVERLY PARK, MD 21142

Paul S. Barring MD

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 30950  
REG. NO. EST

1. DECEASED NAME (TYPE OR PRINT) MATILDA MARIE BREEDLOVE			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 24, 1987		2b. HOUR 12:30 P M					
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 11 - 28 - 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria worker		12b. KIND OF BUSINESS OR INDUSTRY Bakery		
13a. STATE Maryland			13b. COUNTY Anne arundel		13c. CITY OR TOWN Saverna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 721 Cottonwood Dr. / 21146	
14. FATHER'S NAME FIRST MIDDLE LAST Ludwig Lauff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Szubor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 167-24-6026		17. INFORMANT ADDRESS Pauline Liston (Same as # 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Melastasis adenocarcinoma of colon.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>10/16</u> , 19 <u>87</u> , to <u>11/24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Gerald Church</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/24/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERALD CHURCH, M.D.			22e. ADDRESS 8 Evergreen Road Saverna Park, Md. 21146							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-28-87		23c. NAME OF CEMETERY OR CREMATORY White Chapel Gardens		23d. LOCATION Feasterville, Bucks, PA STATE			
24. FUNERAL DIRECTOR ROBERT S. BARRANCO SEVERNA PARK, MD. 21146			25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30951 EST

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MARY MIDDLE MARGARET LAST BRIDGERS			MONTH NOVEMBER DAY 16, YEAR 1987			945 PM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White	MONTH 11 DAY 3 YEAR 06		81 YRS.		MONTHS		DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina	USA				ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL			Housewife				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md.			A. Arundel	Mayo	3920 Callawasse Rd. 21106			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST Ernest MIDDLE W. LAST Hill			FIRST Mary MIDDLE Alma LAST Mott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			246076737		Irving H. Bridgers, Sr. same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD Diabetes Mellitus</u> PART 2. OTHER SIGNIFICANT CONDITIONS <u>Contributing to death but not related to the terminal disease or condition given in part 1 is</u> <u>Arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
		HOUR A.M. MONTH DAY YEAR P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/19/87</u> to <u>11/16/87</u> , that (I) (we) lost saw the deceased alive on <u>11/16/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death <u>87</u>								
22b. SIGNATURE				DEGREE		22c. DATE SIGNED		
<u>Mistafa C. Oz, M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>11/17/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
MISTAFA C. OZ, M.D.				605 BALTIMORE & ANNAPOLIS BLVD SEVERNA PARK, MARYLAND 21146				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		11/19/87		Hillcrest Cemetery		CITY OR TOWN COUNTY STATE		
						Davidsonville A.A. Md.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS				NOV 20 1987		<u>Davidsonville</u>		
Hardesty Funeral Home, Annapolis, Md.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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10/10/1964

WINE MARKET COMPANY

WINE MARKET COMPANY

WINE MARKET COMPANY

WINE MARKET COMPANY

WINE MARKET COMPANY

WINE MARKET COMPANY

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30952

1- FOR  
STATE  
REGISTRAR

DECLASED NAME (PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED				MONTH	DAY	YEAR	2b. HOUR		
XAVIER J. BROOKUS						11 8 19 87									
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	7d. HOUR		
Male	White	Jan. 28, 1904	83 YRS.			11 8 19 87							7:50 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.				Anne Arundel County MD.									
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis		Anne Arundel General Hospital				Butcher			Self						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
PA		Luzerne		Mountaintop				520 Church Rd. 18707							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
(UNKNOWN)				(UNKNOWN)											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT									
No				Unknown		Mountaintop, PA 18707 Leo Brookus, 66 Woodlawn Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chest injuries complicating hypertensive arteriosclerotic</u> <u>cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11-2- 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject slipped while in shower.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3635 Branum Rd., Edgewater, Anne Arundel, MD									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY) Assistant				DATE SIGNED				11-9-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Charles P. Kokes, M.D.				111 Penn St., Balto., MD				21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				Nov. 12, 1987		Calvary				Butler Twp., Luzerne, PA					
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, Md. 21214												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
												NOV 10 1987		Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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WATER-REDUCING ADJ



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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30953

1. DECEASED NAME (TYPE OR PRINT) <b>Joe Wheeler Brown</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 11, 1987</b>			2b. HOUR <b>4 P. M.</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>			
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
10. CITY OR TOWN OF DEATH <b>Harwood</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Grashears Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Ret. Member</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>			
13a. STATE <b>MD</b>				13b. CITY OR TOWN <b>Edgewater</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>405 Silver Run Road 21037</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Peter Brown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida J. Teel</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>NO</b>			
17. SOCIAL SECURITY NO. <b>518-036458</b>				18. INFORMANT <b>Rose Virginia Brown</b>				19. ADDRESS <b>Same as #13</b>			
20. CAUSE OF DEATH (Enter only one cause per item 11a, 11b, and 11c) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF c) <b>Had a bad fall in 1986</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c: <b>Had a bad fall in 1986</b>											
21a. DATE OF OPERATION <b>none</b>			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			22a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			24c. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Lothian Md 20711</b>					
25. I certify that (I) this hospital attended the deceased from <b>July 13, 1987</b> to <b>Sept 11, 1987</b> , that (I) (we) last saw the deceased alive on <b>Sept 11, 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
26. SIGNATURE <b>Charles H. Wirth M.D.</b>				27. DEGREE <b>M.D.</b>				28. DATE SIGNED <b>11/11/87</b>			
29. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles H. Wirth M.D.</b>				30. ADDRESS <b>Lothian Md 20711</b>							
31a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>			31b. DATE <b>Nov 13 1987</b>			31c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>			31d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>		
32. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis MD</b>				33. ADDRESS <b>NOV 13 1987</b>				34. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>		35. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30954

1. DECEASED NAME (Type or Print) <b>Kenneth V. Brown</b>		2a. DATE KNOWN OF DEATH MONTH <b>11</b> DAY <b>13</b> YEAR <b>1987</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Male</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>26</b> YEAR <b>29</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>58</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Deputy Sheriff</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Bowie</b>
14. FATHER'S NAME FIRST <b>Kenneth</b> MIDDLE <b>V.</b> LAST <b>Brown, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b>I.</b> LAST <b>Gill</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>
17. INFORMANT <b>Suzanne K. Brown</b>		18. SOCIAL SECURITY NO. <b>167-22-4706</b>		19. ADDRESS <b>11250 Westport Drive Bowie, Maryland 20715</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>A.S.C.V.D.</b> (b) <b>A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>William P. Jones MD</b>		TITLE (SPECIFY) <b>DEPUTY</b>		DATE SIGNED <b>11/14/87</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>WILLIAM P. JONES, M.D.</b>		ADDRESS <b>695 America Ct. 21035</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>NOV 17, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Landolt</b>
26. ADDRESS <b>6000 Annapolis Road Bowie, Maryland 20715</b>		27. COUNTY <b>Montgomery, MD</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))



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2557 NOV 20 1987

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 3095 EST  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOYCE ELAINE BUTTS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 16 1987</b>			2b. HOUR <b>1155 AM</b>				
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 15 1940</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EKG Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Arundel Hospital</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>452 Aventura Ct. 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Ramsey</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (Husband) ADDRESS <b>Mr. Bruce W. Butts, Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer ovary</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>metastasis to peritoneum</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>[Signature]</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASANT K. KHANDLWAL M.D.</b>			22e. ADDRESS <b>7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>			23b. DATE <b>Nov 20 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Co. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

NOVEMBER 10 1957 AM

STUTTS

JOYCE

AND WINDHOL COUNTY

WEST WINDHOL HOSPITAL

GLENN BERTIE

GLENN BERTIE, WINDHOL 11061  
JAMES B. BARTON, WINDHOL 11061

WINDHOL 11061

71330 NOV 10 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 3095556

1. DECEASED NAME (TYPE OR PRINT) <b>RENA C CADARETTE</b>			2a. DATE OF DEATH MONTH <b>NOVEMBER</b> DAY <b>6</b> YEAR <b>1987</b>			2b. HOUR <b>1205 AM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>12</b> YEAR <b>1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Retail Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Caldor Dept</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>108 Martha Road 21061</b>		
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b></b> LAST <b>Curtis</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b></b> LAST <b>Colby</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>005-09-9462</b>		17. INFORMANT <b>Curtis A. Cadarette, 706 Wooddale Rd.</b>			ADDRESS <b>Linthicum, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pseudobulbar Palsy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart Failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>→ Hypertension, total infarct</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>5/27</b> 19 <b>81</b> , to <b>11/6</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert B. Kroopnick</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. KROOPNICK, M.D.</b>					22e. ADDRESS <b>95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 10, 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>			
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WHEAT ARMY CORPS

NORTH ARMY HOSPITAL

GLENN BURNETT

GLENN BURNETT, MARYLAND 21081  
82 ARMY ROAD, SUITE 102

ROBERT D. BROOKS, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 30957 REG. NO.			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR 2b HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 1-987 William Day Carr Sr.				20. DATE OF DEATH MONTH DAY YEAR 2b HOUR November 5, 1987 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-4-1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Electrical	
13a. STATE Md.		13b. COUNTY Anno		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Amos Chesterfield Carr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Walstrom		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-12-9908	
17. INFORMANT Amos Carr		17. ADDRESS Crownsville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Cellulitis of inguinal area DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 19 11/3/87, to 19 11/5/87, that (I) (we) lost the deceased alive on 11/3/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Carol Pressey MD	
22c. DATE SIGNED 11/5/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL PRESSEY MD		22e. ADDRESS 3 VILLAGE GREEN, CROTON, MD		22f. SIGNATURE Carol Pressey	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-7-87		23c. NAME OF CEMETERY OR CREMATORY Baldwin Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville Anno Md.	
24. FUNERAL DIRECTOR NAME T.A. Hardesty		24. ADDRESS Annapolis Md. 21401		25a. DATE REC'D. BY REGISTRAR NOV 6 1987		25b. REGISTRAR'S SIGNATURE David R. Riddle	

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COTTON & CO.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corollary papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <u>Arthur Claude Christopher</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>11-5-87</u>					2b. HOUR <u>2:32 PM</u>	
3. SEX <u>Male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>01 20 07</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>80</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE Arundel</u> MD.		
10. CITY OR TOWN OF DEATH <u>ANnapolis</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ANNE Arundel GEN. Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <u>Draftsman</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>			13b. COUNTY <u>AA</u>		13c. CITY OR TOWN <u>Annapolis</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>Hearne Road, Apt 206 21401</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>John D. Christopher</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Jennie Ellrod</u>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>			16b. SOCIAL SECURITY NO. <u>169-10-3259</u>		
17. INFORMANT ADDRESS <u>Yvonne Kranitz-Annapolis MD 21401</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute C.F. BLEED</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>kidney</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>19 1983</u> to <u>11-5-87</u> , that (I) (we) lost saw the deceased <u>live</u> on <u>11-5-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Anthony M. Caputo</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>11-5-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Anthony M. Caputo MD</u>				22e. ADDRESS <u>132 Holiday Ct. #201 - Annapolis MD 21401</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>Nov. 9, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Pittsburgh Allegheny PA</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Taylor Funeral Chapel Annapolis MD</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 13 1987</u>				25b. REGISTRAR'S SIGNATURE <u>Julia Division-Randall</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30959

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) Marguerite G. Coffinberger		MONTH DAY YEAR November 21, 1987		M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH May 20, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		10. CITY OR TOWN OF DEATH Rivera Beach		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 251 Arundel Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marker		12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.		13a. STREET ADDRESS / ZIP CODE 251 Arundel Road 21122	
14. FATHER'S NAME Benjamin Franklin Johnston		15. MOTHER'S MAIDEN NAME Nellie Custer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 226-12-0135		17. INFORMANT Daniel H. Coffinberger		ADDRESS 251 Arundel Rd. Rivera Beach	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> , 19 <u>87</u> , to <u>11/21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>S.P. Mundra</i>		DEGREE MD		22c. DATE SIGNED 11/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.P. Mundra, M.D.		22e. ADDRESS 203 E. Patapsco Ave. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Nov. 24, 1987		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Maus.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. DATE REC'D. BY REGISTRAR NOV 23 1987		23f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
24. FUNERAL DIRECTOR NAME ADDRESS McCurly Funeral Home Pasadena, Maryland					

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30960

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			2b. HOUR				
Violet			C.			Conrad						X MONTH DAY YEAR			11 21 87				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			7d. HOUR				
Female		Caucasian		July 31, 1920		67 YRS.		MONTHS DAYS HOURS MIN				11 21 87			12 noon				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania				United States								ANNE ARUNDEL County, MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Glen Burnie				NORTH ARUNDEL HOSPITAL				Housewife				Own Home							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Pennsylvania				Blair				Altoona				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				RD #2, Box 282 16601			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
Frank J. Greiner				Annabelle Mutzabaugh															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
No				173-14-0208				Earl E. Conrad				same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) <u>ASCD</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
<u>Diabetes Mellitus</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY?	
																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>William P. Jones</u>										TITLE (SPECIFY) <u>DEPUTY</u>				DATE SIGNED <u>11/22/87</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>WILLIAM P. JONES, M.D.</u>										ADDRESS <u>695 America Ct. 21035</u>				Annapolis, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				Nov. 25, 1987				Calvary Cemetery				Altoona Pennsylvania							
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland</u>										25a. DATE REC'D. BY REGISTRAR <u>NOV 24 1987</u>				25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rucker</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

(VR A15 ME (5))

18-12-11

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8730961  
REG. NO.FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES J. CONROY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/19/87</b>		2b. HOUR M
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 10, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3309 Harness Creek Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Teacher</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>21403 3309 Harness Creek Road</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles R. Conroy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret M. Bachman</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>187-09-0536</b>		17. INFORMANT ADDRESS <b>Same as #13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cigarette use</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>50 yrs</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21 mos</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/22/87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11/19/87</b>
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Stuart E. Selonick, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/20/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart E. Selonick, M.D.</b>		22e. ADDRESS <b>51 Franklin St. Annapolis, Md. 21014</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 23, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gethsemane</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laureldale Berks PA</b>
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>		
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11/11/50

1. The Bureau of Internal Revenue is hereby notified that the following information is being furnished to the Bureau of Internal Revenue for its use in the administration of the Internal Revenue Code:

2. The Bureau of Internal Revenue is hereby notified that the following information is being furnished to the Bureau of Internal Revenue for its use in the administration of the Internal Revenue Code:

3. The Bureau of Internal Revenue is hereby notified that the following information is being furnished to the Bureau of Internal Revenue for its use in the administration of the Internal Revenue Code:



071809 NOV

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8730962  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: <i>Helen</i> MIDDLE: <i>Huelat</i> LAST: <i>Cooke</i>			2a. DATE OF DEATH MONTH: <i>November</i> DAY: <i>5</i> YEAR: <i>1987</i>		2b. HOUR <i>3:25am</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH: <i>Sept</i> DAY: <i>7</i> YEAR: <i>1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i>	IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Severna Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian Nursing Center</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Resource</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: <i>Maryland</i> 13b. COUNTY: <i>Anne Arundel</i> 13c. CITY OR TOWN: <i>Crofton</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>1853 Marlow Pl./21114</i>	
14. FATHER'S NAME FIRST: <i>John</i> MIDDLE: <i>Herbert</i> LAST: <i>Huelat</i>			15. MOTHER'S MAIDEN NAME FIRST: <i>Annie</i> MIDDLE: <i>L.</i> LAST: <i>Moore</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>058-07-1385</i>		17. INFORMANT ADDRESS <i>Linda C. Sorkin, Same as # 13.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alzheimer's</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>arteriosclerosis</i>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from *July*, 19 *86*, to *Nov 5*, 19 *87*, that (I) (we) last saw the deceased alive on *Nov 2*, 19 *87*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Mustafa C-Oz MD</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>Nov 5, 87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MUSTAFA C-OZ MD</i>		22e. ADDRESS <i>605 B &amp; A Blvd SP Md 21146</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>Nov. 6, 1987</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>	23d. LOCATION CITY OR TOWN: <i>Alexandria, Virginia</i> COUNTY: STATE:
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24. FUNERAL DIRECTOR NAME: <i>Beall Funeral Home</i> ADDRESS: <i>16000 Annapolis Rd. Bowie, Maryland 20715</i>	25a. DATE REC'D. BY REGISTRAR <i>NOV 13 1987</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0963

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
GRACE		E.		CORY				11-18-87		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Female	White	4 07 24		63 YRS.						11-18-87 2:15p	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Texas		USA				Anne Arundel County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		7501 Furnace Br. Rd.				Nurse		US Gov't			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MD		Anne Arundel		Pasadena				611 Eliot Rd. Pasadena, MD 21122			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Wesley McClure				Melita Horney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				461-22-9627		Ross Cory		611 Eliot Rd. Pasadena, MD 21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of neck</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-lying cause last.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:06p 11-18-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7501 Furnace Br. Rd. anne Arundel Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				MARGARITA A. KORELL, M.D. Assistant				DATE SIGNED 11-19-87			
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D.				ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		11-23-87		Olive Branch Cemetery		Miller Co.		Arkansas			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
McCully Funeral Home Pasadena, MD 21122						NOV 23 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

20% COTTON FIBER

WINTERFLEX

DAVID



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 30964

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) EVELYN Maybell CRAIG		2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 29, 1987		2b. HOUR EDT 1247 AM	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 23 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN PASADENA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 112 DISNEY AVE 21122	
14. FATHER'S NAME FIRST MIDDLE LAST William Robert Gray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie M. Mayberry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Daughter) ADDRESS Mrs. Sue E. Littleton Salisbury, Md 21801 300 Brookview Dr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic coronary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus; history cerebrovascular accident 3/85</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from above, (I) saw (did) (did not) view the body after death.					
22b. SIGNATURE J. B. Skarbek		DEGREE M.D.		22c. DATE SIGNED 11-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR JERRY SKARBEK M.D.		22e. ADDRESS 3708 MOUNTAIN ROAD PASADENA MD 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Co Maryland		23e. REGISTRAR'S SIGNATURE DEC 01 1987			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md.		24b. DATE RECEIVED BY REGISTRAR			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper "Pages 1 and 2" should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please take this certificate, pages 1 and 2, should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LILLIAN EVELYN CROMPTON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 19, 1987</b>			2b. HOUR PM <b>1143 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasion</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 25, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>366 South Drive 21146</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Dietrich</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Riley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212769152</b>		17. INFORMANT ADDRESS <b>Richard H. Crompton (Same as above)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cholesteremic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Cerebral Infarction</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jose M. Presbitero, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/20/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSE M. PRESBITERO, M.D.</b>				22e. ADDRESS <b>7845 OAKWOOD ROAD, SUITE 107 GLEN BURNIE, MARYLAND 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-23-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD Veterans Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville A.A. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Jim</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John D. Gordon</b>			
26. NAME OF FUNERAL HOME <b>ROBERT S. BARRANCO SEVERNA PARK MD. 21146</b>									

13-03-80

ANDREW J. BROWN

ALB BROWN  
WEST ABERDEEN HOSPITAL

THIS CARD WAS SENT TO  
THE BIRMINGHAM, ENGLAND 1900

JOHN J. WOODWARD, M.D.

071156 NOV -9

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30966 EST

1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND N CRONHARDT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 04, 1987</b>		2b. HOUR <b>752 PM</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>November 9, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Photography</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond R. Cronhardt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mae Nickle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217 03 6983</b>		17. INFORMANT ADDRESS <b>Vivian J. Deters (Same as 13a-e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute coronary suspect</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE, LIST.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>(1) PVD (2) HT Congioplasty (3) claudication</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/2</b> , 19 <b>87</b> , to <b>11/4</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11/2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Elmo Gayoso</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELMO GAYOSO, M.D.</b>		22e. ADDRESS <b>273-F PENINSULA FARM ROAD ARNOLD, MARYLAND 21012</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 7, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Dundalk</b>		COUNTY <b>Baltimore</b>		STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>		ADDRESS <b>3204 Mountain Rd. Pasadena, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

071128 NOV-98

REF

CROMWELL

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DAY/END

NOVEMBER 06, 1997

ANNIE ARNOLD COUNTY

NORTH ARNOLD HOSPITAL

GLENN BIRNIE

071128 NOV-98

ELMO GAYSON, M.D.

ARNOLD, MARYLAND 21013  
275-F MONTGOMERY PARK ROAD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by carrier.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8730967 EST

1- FOR  
STATE  
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) <b>BERTHA S. DARNELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 13, 1987</b>		2b. HOUR <b>0908 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE ADDRESS IN FULL) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKER</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>A.A.</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE <b>313 Hospital Drive 21061</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>RICHARD SINES</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE SICKLE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>414 32 6339</b>		17. INFORMATION <b>Odenton, Maryland 21113</b> <b>Isabelle Lapere 531 Prince Charles Av</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>gastrointestinal bleeding</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> , 19 <b>87</b> , to <b>11/15</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11/13</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. Karipineni M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/13/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. KARIPINENI, M.D.</b>		22e. ADDRESS <b>200 HOSPITAL DRIVE SUITE 300 GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11/16/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Raleigh Wake N.C.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Raymond C. Fink Glen Burnie, Md 21061</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

BP

1104 11 18 17

NOVEMBER 13, 1917

WASH. COUNTY

WASH. COUNTY

WASH. COUNTY

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WASH. COUNTY

WASH. COUNTY

WASH. COUNTY

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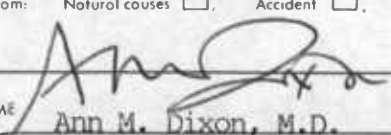

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00968

1. DECEASED NAME (TYPE OR PRINT) <b>Phillip (Philip)</b>		MIDDLE <b>Davis, Sr.</b>		LAST <b>Davis, Sr.</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>11-1</b> YEAR <b>1987</b>		2b. HOUR <b>2:48</b>	
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>25</b> YEAR <b>1957</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>29</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>11-1</b> 19 <b>87</b>		2d. HOUR <b>2:48</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>			
10. CITY OR TOWN OF DEATH <b>Anne Arundel</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ritchie Motel</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>Super Fresh</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2107 Baker Street 21217</b>	
14. FATHER'S NAME FIRST <b>Christopher</b> MIDDLE <b>Davis, Sr</b> LAST <b>Davis, Sr</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>M.</b> LAST <b>Williams</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-64-1422</b>		17. INFORMANT ADDRESS <b>Bernadette Davis 2107 Baker Street</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Narcotic intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:00AM 11-1, 87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject took drugs</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>motel</b>		21f. LOCATION STREET <b>Ritchie Motel, Rte. 2 and 11th Ave</b> CITY OR TOWN <b>Anne Arundel Co., MD</b> COUNTY <b>MD</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> .									
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Deputy Chief</b>				DATE SIGNED <b>11-1-87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/6/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Randallstown</b> COUNTY <b>MD</b> STATE <b>MD</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 06 1987</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West</b> ADDRESS <b>4300 Wabash Avenue</b>		25a. REGISTRAR'S SIGNATURE 							

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RECEIVED 2002

CHIEF OF POLICE



*[Handwritten signature]*

NOV 8 0 00 PM

074456 DEC-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REF. NO. 30959

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
Patricia Deloatch								XX 11-27 19 87								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Black	February 22, 1967		20 RS.						11-27 19 87						7:10 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
North Carolina		USA				Anne Arundel County, MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Laurel		Forest Haven-D.C. Children's Cntr.		None		None											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Anne Arundel		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3360 Center Ave. 20707									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Tommy Lee DeLoutch		Annie Mae---															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		214 82 0215		Phyllis Smith, S/W,		Forest Haven Laurel, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Seizure Disorder		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
				DUE TO, OR AS A CONSEQUENCE OF													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				Mental Retardation													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Margarita A. Korell, M.D.		Assistant		11-28-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Margarita A. Korell, M.D.		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		Dec. 3, 1987		Harmony Cemetery		Landover, Prince Georges, Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
W.W. Chambers Co.,		517 11th St., SE, Wash., D.C.		DEC-7-1987													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 30970  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frederick H. Dorsey Sr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 15, 1987</b>		2b. HOUR MIN. <b>10:10 A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 28, 1908</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		10. CITY OR TOWN OF DEATH <b>Severna Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>133 Downing Drive</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mason Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13b. STREET ADDRESS / ZIP CODE <b>133 Downing Dr. 21146</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>George Frederick Dorsey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Louise Jones</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220 075691</b>		17. INFORMANT ADDRESS <b>Catherine Beverly Severna Park, Md.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC LUNG CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that I (this hospital) attended the deceased from <b>APRIL 22, 1986</b> to <b>NOVEMBER 15, 1987</b> , that I (we) last saw the deceased on <b>SEPTEMBER 8, 1987</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.)							
22a. SIGNATURE <b>Diana H. Griffith</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/15/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DIANA H. GRIFFITH</b>		22e. ADDRESS <b>900 CATON AVE. BART. MD. 21009</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-18-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Sykesville Carroll Md.</b>	
24. FUNERAL DIRECTOR NAME <b>WRIGHT F.H. Box 195 Sykesville, MD. 21784</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>James R. Ponder</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-pages. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 then any injury or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		FIRST CERTIFICATE OF DEATH		REG. NO. 3 0 9 7 1	
LAST		FIRST		LAST		DATE OF DEATH		MONTH DAY YEAR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. SEX		4. RACE		5. DATE OF BIRTH	
Downs, Ada		November 14, 1987		F.		BLACK		10/13/22	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. AGE (IN YEARS LAST BIRTHDAY)	
MARYLAND		U.S.A.				Anne Arundel		165 YRS.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
ANNAPOLIS		ANNE ARUNDEL GENERAL HOSPITAL		MARYLAND		ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
CHARLES E. SMITH		ALICE M. SELLMAN		NO				Annapolis, Md. 21401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
Aspirin - Fentanyl								HOUR A.M. MONTH DAY YEAR	
DUE TO, OR AS A CONSEQUENCE OF								P.M. 19	
Acute Pulmonary Embolism									
DUE TO, OR AS A CONSEQUENCE OF									
ARVD									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		22a. DATE SIGNED		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
myeloid leukemia CA; Myeloid leukemia		11/14/87		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11/14/87		Richard Colgan	
23a. BURIAL CREMATION, REMOVAL		23b. NAME OF CEMETERY OR CREMATORY		23c. LOCATION		23d. DATE REC'D. BY REGISTRAR		23e. REGISTRAR'S SIGNATURE	
BURIAL		PINELAWN MEM. PARK		Annapolis A.C. Maryland		NOV 23 1987		Julia Davidson-Randall	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
WILLIAM REESE & SONS MORTUARY, P.A.		NOV 23 1987		Julia Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8730972

REG. NO.

1. DECEASED NAME (PRINT) ANNIE DUCKETT		2a. DATE OF DEATH MONTH DAY YEAR 11 16 87		2b. HOUR 12 <sup>30</sup> P. M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 9 9 1902	6. AGE (IN YEARS LAST BIRTHDAY) 85	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BAY MANOR NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND	13b. COUNTY A.A.	13c. CITY OR TOWN LOTHIAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1038 Bayard Road 20711
14. FATHER'S NAME FIRST MIDDLE LAST FRANK DUCKETT	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-28-3509		17. INFORMANT ADDRESS Lothian, Md. 20711 ALICE T. TYLER 1038 Bayard Road		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF BREAST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE PULM. DISEASE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7-9-1987</u> to <u>11-16-1987</u> , that (I) (we) last saw the deceased alive on <u>11-11-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)				
22b. SIGNATURE <u>C. V. Cyriac M.D.</u>	DEGREE M.D.	22c. DATE SIGNED 11-17-87	22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.V. CYRIAC. M.D.	
22e. ADDRESS 14 WELLSHAMUR GLENBURNIE. MD 21061.	22f. ADDRESS 14 WELLSHAMUR GLENBURNIE. MD 21061.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11-20-1987	23c. NAME OF CEMETERY OR CREMATORY MOSES CEMETERY	23d. LOCATION CITY OR TOWN Drury	23e. COUNTY A.A. Maryland
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.	25a. DATE REC'D. BY REGISTRAR NOV 23 1987		25b. REGISTRAR'S SIGNATURE Alicia Davidson-Randall	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30973

1 DECEASED NAME (TYPE OR PRINT) <b>David John Dunigan Jr</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Nov. 11, 1987</b>		2b HOUR <b>M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01 18 22</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>	
10 CITY OR TOWN OF DEATH <b>Arnold</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8 Old Sturbridge Road</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Exec. Estate</b>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <b>MD</b>	13b COUNTY <b>AA</b>	13c CITY OR TOWN <b>Arnold</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>David John Dunigan Sr</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen White</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>577-38-5454</b>		17. INFORMANT ADDRESS <b>Carol H. Dunigan - #13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Broaf</b> <b>Many years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>11/7</b> , 19 <b>79</b> , to <b>11/10</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/9</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.					
22a. SIGNATURE <b>Richard I. Hochman</b>				22c. DATE SIGNED <b>11/11/87</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard I. Hochman</b>				22d. ADDRESS <b>16 Murray Ave Annapolis, MD 21401</b>	
23a. BURIAL, CREMATION, REMOVAL (RECEIPT) <b>Cremation</b>		23b. DATE <b>Nov. 13, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG MD</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia A. ...</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows city injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 0 9 7 EST				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES H DURNER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 06, 1987</b>				2b. HOUR <b>916 PM</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 11 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Ordin. Depo</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Rivera Bch</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rivera Beach, MD</b>		13f. <b>8431 Bay Rd. 21122</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Durner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-14-6336</b>		17. INFORMANT ADDRESS <b>Matilda Grove same as above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPTIC SHOCK</b>							<b>5 HRS.</b>	
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>IRRITABLE SIDEROBLASTIC ANEMIA; AORTIC STENOSIS; ANGINA</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from <b>10-27-87</b> to <b>11-6-87</b> , that (b) (we) last saw the deceased alive on <b>11-6-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) did not view the body after death.								
22b. SIGNATURE <b>JOSE P. NEPOMICENO, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-6-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSE P. NEPOMICENO, M.D.</b>				22e. ADDRESS <b>7845 OAKWOOD ROAD, SUITE 107 GLEN BURNIE, MARYLAND 21061</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-10-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>		
24. FUNERAL DIRECTOR NAME <b>McCurry Funeral Home</b>				ADDRESS <b>Pasadena MD 21122</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1987</b>		
				25b. REGISTRAR'S SIGNATURE <b>Donner</b>				

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RECEIVED

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Quinton</u> MIDDLE <u>nmn</u> LAST <u>Emery</u> <u>Quinton Emery</u>		2a. DATE OF DEATH MONTH <u>11</u> DAY <u>21</u> YEAR <u>87</u> <u>11-21-87</u>		2b. HOUR <u>5.05</u> A M	
3. SEX <u>MALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH <u>03</u> DAY <u>01</u> YEAR <u>20</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.J.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS.	
10. CITY OR TOWN OF DEATH <u>ANNAPOLIS</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ANNE ARUNDEL GEN. HOSP.</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE ARUNDEL</u> MD.	
13a. STATE <u>MD.</u>		13b. CITY OR TOWN <u>STEVENSVILLE</u>		13c. STREET ADDRESS <u>105 ALLEGHANY Rd. 21666</u>	
14. FATHER'S NAME FIRST <u>LEONARD</u> MIDDLE <u></u> LAST <u>EMERY</u>		15. MOTHER'S MAIDEN NAME FIRST <u>BEATRICE</u> MIDDLE <u>QUINTON</u> LAST <u></u>		12b. KIND OF BUSINESS OR INDUSTRY <u>FARMER &amp; MACHINIST FARMING</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>15676-0220</u>		17. INFORMANT <u>ELIZABETH EMERY</u> ADDRESS <u>105 ALLEGHANY Rd. STEVENSVILLE MD 21666</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chemotherapy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Gastric cancer</u>					
19a. DATE OF OPERATION <u></u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u></u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>1984</u>		21f. LOCATION STREET <u>11/21</u> CITY OR TOWN <u>87</u> COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>11/20</u> 19 <u>87</u> , to <u>11/21</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>11/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stuart E. Selonick, M.D.</u>				22c. DATE SIGNED <u>11/21/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stuart E. Selonick</u>				22e. ADDRESS <u>51 Franklin St Annapolis, Md. 21401</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>11-21-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Security Process, Inc.</u>	
23d. LOCATION CITY OR TOWN <u>Balt.</u> COUNTY <u>Balt.</u> STATE <u>MD</u>		24. FUNERAL DIRECTOR NAME <u>TOM HELFENBEIN</u> ADDRESS <u>RT#1 Box 66-9 CHESTER MD 21619</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 30 1987</u>	
25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>					

073-12-101

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

073621 DEC 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7a, Nursing G634 12-7-84 dw  
 FOR STATE REGISTRAR per funeral director  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

87 REG. NO. 30976

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harold Edward Fawthrop</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 26 87</i>			2b. HOUR <i>11:10 P</i> M	
3. SEX <i>male</i>		4. RACE <i>Cauc</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 4 17</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.	
10. CITY OR TOWN OF DEATH <i>Millersville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Knollwood Manor</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Self-employed</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Sancti Travel</i>		13a. STATE <i>Md</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Pasadena</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edward Fawthrop</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Hoxan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>			
16b. SOCIAL SECURITY NO. <i>WW II</i>		16c. SOCIAL SECURITY NO. <i>217-09-8218</i>		17. INFORMANT ADDRESS <i>Mrs. Adyne Fawthrop (same as 13)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic lung cancer</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Seizure disorder, COPD</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		22c. DEGREE <i>MD</i>				22d. DATE SIGNED <i>11/27/87</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Basant K Khandelwal</i>		22f. ADDRESS <i>7422 Belto Annab Road Glen Burne</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-30-1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Md. Veterans Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Crownsville A.A. Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Corranco Funeral Home Severna Park</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 01 1987</i>			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30977 EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTHA R FISHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 14, 1987</b>		2b. HOUR <b>1140 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 9, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOK KEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>PASADENA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>MAURICE ROBINETTE MORRIS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LORENA MAE LASHLEY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-12-8450</b>		17. INFORMANT ADDRESS <b>JOHN S. FISHER, JR. (SAME AS 13A-E)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure and</b> DUE TO, OR AS A CONSEQUENCE OF <b>cardiac arrhythmia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV. 4, 1987</b> to <b>NOV. 12, 1987</b> , that (I) (we) last saw the deceased alive on <b>NOV. 12, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>NOV. 15, 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES J. WU, MD</b>		22e. ADDRESS <b>7845 OAKWOOD ROAD #204 GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>Nov. 17, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELK RIDGE HOWARD MD</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



073763 DEC - 87

STATE OF MD  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG No 0978

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
William		H.		Fitzgerald				XX		11-28		19		87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	12 17 1929		57 YRS.						11-28		19		87		12:02 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Va		U S A										Anne Arundel County,				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Glen Burnie		North Arundel Hospital														Bethlehem Steel	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md				Baltimore		YES XX NO		4219 Eldone Road 21229									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
William		Thelma														Morgan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		229-34-4038		Ruby Fitzgerald		4219 Eldone Road											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		DUE TO, OR AS A CONSEQUENCE OF															
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES XX NO											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Margarita A. Korell, M.D.		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED		11-29-87							
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS		111 Penn St., Balto., Md.		21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		12/5/87		Church Cemetery		Blackstone Va											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H West		4300 Wabash Avenue		DEC 02 1987		Julia Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

131-000-301



074087 DEC

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 0979

1. DECEASED NAME (TYPE OR PRINT) JAMES VINCENT FITZPATRICK, SR.			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 26, 1987		2b. HOUR 9:15A M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 12 18 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 960 WOODLAND CIRCLE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSE MANAGER	
12b. KIND OF BUSINESS OR INDUSTRY GIANT FOOD		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 960 WOODLAND CIRCLE 21401		14. FATHER'S NAME FIRST MIDDLE LAST JAMES FITZPATRICK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE DESH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-28-6714		17. INFORMANT ADDRESS PATRICIA A. FITZPATRICK WIFE SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 2</u> , 19 <u>79</u> , to <u>OCT 13</u> , 19 <u>87</u> , that (I) (we) lost <u>10/13</u> <u>1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/27/1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. SOOD M.D.		22e. ADDRESS 6911 LAUREL-BOWIE ROAD BOWIE, MARYLAND 20716					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE NOV. 30, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD.	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 03 1987			
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove earlier papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-23 870-150

DEC 03 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain with the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other infirmity, the medical examiner must be notified at once.

BP

DHMH - 16 50M / 1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30980 EST

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>EMMA</b>		NOVEMBER 15, 1987		1035 PM	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Apollo, PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO. <b>159-28-4097</b>	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		21. SOCIAL SECURITY NO. <b>159-28-4097</b>		22. DATE SIGNED	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>End Stage Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		25. DATE REC'D. BY REGISTRAR	
26. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____		27. DATE SIGNED		28. DATE REC'D. BY REGISTRAR	
29. DATE OF OPERATION		30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET CITY OR TOWN COUNTY STATE	
38. I certify that (I) (this hospital) attended the deceased from <b>11/2 19 87</b> to <b>11/15 19 87</b> , that (I) (we) last saw the deceased alive on <b>11/15 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		39. SIGNATURE <b>Recep Erol</b>		40. DEGREE	
41. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RECEP EROL M.D.</b>		42. ADDRESS <b>325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061</b>		43. DATE SIGNED	
44. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		45. DATE <b>Nov. 19, 87</b>		46. NAME OF CEMETERY OR CREMATORY <b>Greenwood Mem. Park</b>	
47. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b>		48. ADDRESS		49. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 REG. NO. 3 0 9 8 1

1. DECEASED NAME (TYPE OR PRINT) <i>Edward J. Hawrinski</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct. 24 1987</i>			2b. HOUR M	
3. SEX <i>M.</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH DAY MONTH YEAR <i>7/5/24</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>—</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i>	
10. CITY OR TOWN OF DEATH <i>AA County</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS) <i>30 Margout Ave.</i>				12a. USUAL OCCUPATION (TYPE OF WORK AND MOST OF WORKING LIFE) <i>Retired</i>	
12b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>MD.</i>		13a. COUNTY <i>AA</i>		13b. CITY OR TOWN <i>AA County</i>		13c. STREET ADDRESS <i>30 Margout Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Adam Hawrinski</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Isaac J. Kowski</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>318-14-6682</i>		17. INFORMANT NAME ADDRESS <i>Catherine Kerr 30 Margout Ave.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>POPPING MYOCARDIUM INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>By Pros Surgery</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/7</i> , 19 <i>86</i> , to <i>9/12</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>9/12</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Attattys</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ASAK K Chatterjee</i>		22e. ADDRESS <i>3927 Annapolis Rd. Balto, 21227</i>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i>		23b. DATE <i>10/28/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenview Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Anne Arundel</i>	
24. FUNERAL DIRECTOR NAME <i>Charles D. Stevens</i>		24b. DATE <i>Oct. 13/1987</i>		25a. DATE OF REGISTRATION <i>OCT 26 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

10 75 000 1 7 8 2 0 0



072171 NOV 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on duty.

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 87 30982									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine Pauline Gause						2a. DATE OF DEATH MONTH DAY YEAR November 16, 1987		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 10, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8 Virginia Avenue N.W.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Exxon Oil Co.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2 Hathaway Road 21093	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Gause				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Allen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17. INFORMANT (Brother) John H. Naumann		ADDRESS 8 Virginia Ave. NW Glen Burnie, Md. 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mon.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>87</u> to <u>Nov 16</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Oct 30</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles A. Padgett, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles A. Padgett, M.D.				22e. ADDRESS 5601 Loch Raven Blvd. Baltimore, Maryland 21239					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland			
24. FUNERAL DIRECTOR NAME <u>G. S. Hopkins</u>				ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE <u>Davidson-Pandora</u>	

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RECEIVED

UNCLASSIFIED





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30983

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN L. GAYO</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>1</b> YEAR <b>87</b>		2b. HOUR <b>6:20 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>10</b> YEAR <b>16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO-MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN W. C. HAMMOND'S CARE Foreman</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MD. Drydock</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>-V-L-Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST <b>Christof</b> MIDDLE <b></b> LAST <b>Gayo</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Christina</b> MIDDLE <b></b> LAST <b>JoHann</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-10-3301</b>		17. INFORMANT ADDRESS <b>615 Cromwell St.,</b> <b>Ms. LaVona Arnold Balto.Md. 21225</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesothelioma - Right Lung.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Obstructive Pulmonary Disease; Asbestosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael Schwartz MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-2-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Schwartz MD</b>				22e. ADDRESS <b>606 Harmons Lane 21225</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/4/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Balto.,</b> COUNTY <b>A.A.</b> STATE <b>Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b> ADDRESS <b>237 E. Patapsco Ave.,</b> <b>Balto., Md. 21225</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1987</b>		25b. REGISTRAR'S SIGNATURE <b>James Davidson-Randall</b>	

BP

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MONTANA" and "SOUTH" are faintly visible.]*

072678 NOV 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) PAUL JOSEPH GEAGLONE						2a. DATE OF DEATH MONTH DAY YEAR 11 17 87				2b. HOUR 0918 <sup>M</sup>	
3. SEX Male		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 02-17-29		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Federal Govt.		12b. KIND OF BUSINESS OR INDUSTRY Naval Arch.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN AA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1729 TOKRINGTON PLACE 21115					
14. FATHER'S NAME FIRST MIDDLE LAST Frank J. Geaglone				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Mayard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1948-53		17. INFORMANT Marjorie M. Geaglone				ADDRESS same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF cigarette use Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos. 30 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: c											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/17/87							
22a. I certify that (1) (this hospital) attended the deceased from 8/17/87, 19, to 11/17/87, 19, that (1) (we) lost above (1) (we) did not view the body after death.											
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.				22e. ADDRESS 51 Franklin St. Annapolis, Md 21401							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/20/87		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Funeral Home, Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR NOV 20 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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072604 NOV 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 3098 EST

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD Travis Brodnax Glenn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 15, 1987</b>		2b. HOUR <b>1000 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 19, 1989</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ship Building</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Riviera Bch</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Travis Brodnax Glenn</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Pemberton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Unknown</b>		17. INFORMANT ADDRESS <b>LaRue E. Glenn Same as 13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Lung Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Pulmonary Embolism</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15/87</b> 19 <b>87</b> , to <b>11/15/87</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11/15/87</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Robert Kropp</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/16/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Kropp</b>		22e. ADDRESS <b>8626 Beltsville Rd. #5 Beltsville Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Park</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Howard Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>				
25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Swanson-Lundberg</b>				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
2 - STATE  
3 - REGISTRAR

per med exam

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 0986

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
Hilmar Max Goehring					2c. DATE PRONOUNCED DEAD	11	16	19	87		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.						
Male	White	8 18 36	51 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel County, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		North Arundel Hospital				Machinist-Self Employed					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS					
Md.		AA		Hanover		Hanover, Md. 1510 Green Valley Cir. #21076					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Willi Franz Goehring				Elsa Marguerite Lehe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes Korean War				214-34-4125		Mrs. Sadie C. Goehring #21076					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) splenic hilar injury											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
Cirrhosis of the liver											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		unknown							
		XX 11 16 1987									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
		unknown		unknown							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
TITLE (SPECIFY)											
Deputy Chief											
DATE SIGNED 11/16/87											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St. Balto. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial											
23b. DATE Nov. 19/87											
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery											
23d. LOCATION CITY OR TOWN Baltimore											
COUNTY STATE MD.											
24. FUNERAL DIRECTOR NAME G. G. Roman											
25a. DATE REC'D. BY REGISTRAR NOV 21 1987											
25b. REGISTRAR'S SIGNATURE											

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE SUBMIT THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM TOL 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30987

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANIE BELLE GROOM			2a. DATE OF DEATH MONTH DAY YEAR 11 16 87		2b. HOUR M M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 29 10		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK	
13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Shady Side	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Christopher Carroll Lumpkin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Norris		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214385944		17. INFORMANT ADDRESS Wallace Neal Groom #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DRAIN TUMOR (LYMPHOMA)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 MO.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCT 19 76 to PRESENT 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Harvey J. Steinke MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY J. STEINKE MD				22e. ADDRESS SHADY SIDE MD 20764	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/19/87	23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville A.A. Md.
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home, Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR NOV 20 1987		25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30988

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		200 P.M.	
RUSSELL Ernest GROVE		11 26 87			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
male	Cauc.	MONTH DAY YEAR	76 YRS	IF UNDER 24 HRS	
		08 02 1911			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Illinois	U.S.A.		Anne Arundel MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis	Anne Arundel Gen. Hosp.	Bookbinder	C.P.O.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?	13b. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Lot 130 Boones Mobile Estates		
Maryland Anne Arundel Lothian					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		20711	
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Harry Grove		Jennie Farris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife) Lot 130 Boones Mobile Estates	
Yes-Army W.W.11		328-09-3359-A		Lillian G. Grove Lothian, Maryland 20711	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					1 month
IMMEDIATE CAUSE (a) _____					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
colonic carcinoma s/p colectomy					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
10/27/87		colonic carcinoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/21/87, 19_____, to 11/26/87, 19_____, that (I) (we) lost					
saw the deceased alive on 11/26/87, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Stuart E. Selowick, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Stuart E. Selowick, M.D.		51 Franklin St, Annapolis, Md. 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/01/87		Maryland Veterans Cem.	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Cheltenham P.G. Maryland		DEC 02 1987		Annie S. S. S. S.	
24. FUNERAL DIRECTOR					
Francis Gasch's Sons Funeral Home, P.A.					
4739 Baltimore Avenue Hyattsville, Md. 20781					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "a", item 18 shows any injury, or other traumatic event, the funeral examiner must be notified of once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10-2-10

*[Faint, mostly illegible text covering the majority of the page, appearing to be a list or report.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MILDRED MARIE			MIDDLE GUISE			LAST		
3. SEX F			4. RACE CAU			5. DATE OF BIRTH MONTH 05 DAY 09 YEAR 09			2a. DATE OF DEATH MONTH 11 DAY 6 YEAR 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lost Creek Penna			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co MD		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md			13b. COUNTY AACo			13c. CITY OR TOWN Harwood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST George			MIDDLE			LAST Geise			15. MOTHER'S MAIDEN NAME FIRST Ida		
MIDDLE			LAST Koch			ADDRESS Silver Spring, Md 20904			17. INFORMANT C Glenn Guise 13195 Castle Blvd # 21		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 184 20 0827			17. INFORMANT Silver Spring, Md 20904			17. INFORMANT C Glenn Guise 13195 Castle Blvd # 21		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLANGIOCARCINOMA, EXTRAHEPATIC DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 19 87 to NOVEMBER 19 87, that (I) (we) last saw the deceased alive on Nov 5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael N Peters			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael N. Peters			22e. ADDRESS Franklin/Cathedral Streets. Annapolis, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Nov 9 1987			23c. NAME OF CEMETERY OR CREMATORY Pomfret Manor			23d. LOCATION CITY OR TOWN COUNTY STATE Sunbury Numberland Penna		
24. FUNERAL DIRECTOR NAME HARDESTY FUNERAL HOME			24. FUNERAL DIRECTOR ADDRESS 12 RIDGELY AVE ANN, MD 21401			25a. DATE REC'D BY REGISTRAR NOV 13 1987			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

NOV 01 1917

NOV 01 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 0990 EST

1. DECEASED NAME (LAST OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FRANCES MARGUERITE GUNNING			NOVEMBER 02, 1987			2:45 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		
Female	White	September 4 1913	74 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania	U.S.A.				ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE	NORTH ARUNDEL HOSPITAL			Housewife			Home Maker	
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland			A.A.	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8 Gordon Lane 21061		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Ira Truckenmiller			Nora Levett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			219-28-9427			John Gunning 202 Fifth Ave, Balto Md 21225		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Sepsis</u>								5-6 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myelocytic leukemia</u>								2 months
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>87</u> , to <u>11/2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>R. Karipineni</u>			DEGREE M.D.			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
RANI S. KARIPINENI, M.D.			200 HOSPITAL DRIVE GLEN BURNIE, MARYLAND. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION	
Burial			11/4/87	Holy Cross Cemetery			Baltimore A.A. Md	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George J. Gonca 4001 Ritchie Hwy Balto Md			NOV 3 1987			Julia Benson		

MEDICAL CERTIFICATION

070770 NOV-1 87

FRANCIS

MARGUERITE GUNNING

NOVEMBER 02 1987 2 12 AM

ANNE ARUNDEL COUNTY

NORTH ARUNDEL HOSPITAL

GLENN BURNITE

300 HOSPITAL DRIVE

GLENN BURNITE, MARYLAND, 21061

RAVI S. KARIPINENT, M.D.

NOV 3 1987



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) <b>Bernadette Elizabeth Haas</b>					2a. DATE OF DEATH MONTH <b>11</b> - DAY <b>13</b> - YEAR <b>87</b>		2b. HOUR <b>4:45</b> AM			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>7</b> - DAY <b>25</b> - YEAR <b>16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		IF UNDER 1 YEAR MONTHS <b>YRS</b> DAYS <b>HRS</b> MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ill.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.				
10. CITY OR TOWN OF DEATH <b>Crofton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crofton Nursing Conv.Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Household</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. CITY <b>Md</b> 13b. COUNTY <b>A.A. Co.</b> 13c. CITY OR TOWN <b>Odenton</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>653 Patuxent Rd 21113</b>			
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>King</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Rose</b> MIDDLE <b>Arnold</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>435-03-2788</b>		17. INFORMANT ADDRESS <b>D Lawrence Shinski # 13e</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic Breast Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>11/11</b> , 19 <b>87</b> , to <b>11/13</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/11</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>					DEGREE <b>P RHODES</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P RHODES</b>					22e. ADDRESS <b>1667 Crofton Center Crty</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11-17-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Vincents</b>		23d. LOCATION <b>LaSalle</b> <b>Ill.</b> STATE				
24. FUNERAL DIRECTOR NAME <b>T.A. Hardesty</b> ADDRESS <b>Annapolis Md. 21401</b>					25. RECEIVED BY REGISTRAR <b>NOV 20 1987</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30992

1. DECEASED NAME (TYPE OR PRINT) JEAN RHODES HARDY			2a. DATE OF DEATH MONTH DAY YEAR 11 17 87		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 9 16		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Severna Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1709 Robinhood Rd. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Roy W. Crampton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith West		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579143225		17. INFORMANT 1506 Wheaton Lane Jim Rhodes Silver Spring, Md. 20902	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>5 years.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>87</u> , to <u>11/17</u> , 19 <u>87</u> , that (I) (we) lost <u>spw</u> the deceased above on <u>11/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>11/17/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/18/87	23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto. Md.
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home, Annapolis, Md.			25a. DATE REC'D. BY REGISTRAR NOV 20 1987		
			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. This page should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 30993

REG. NO.

EDT

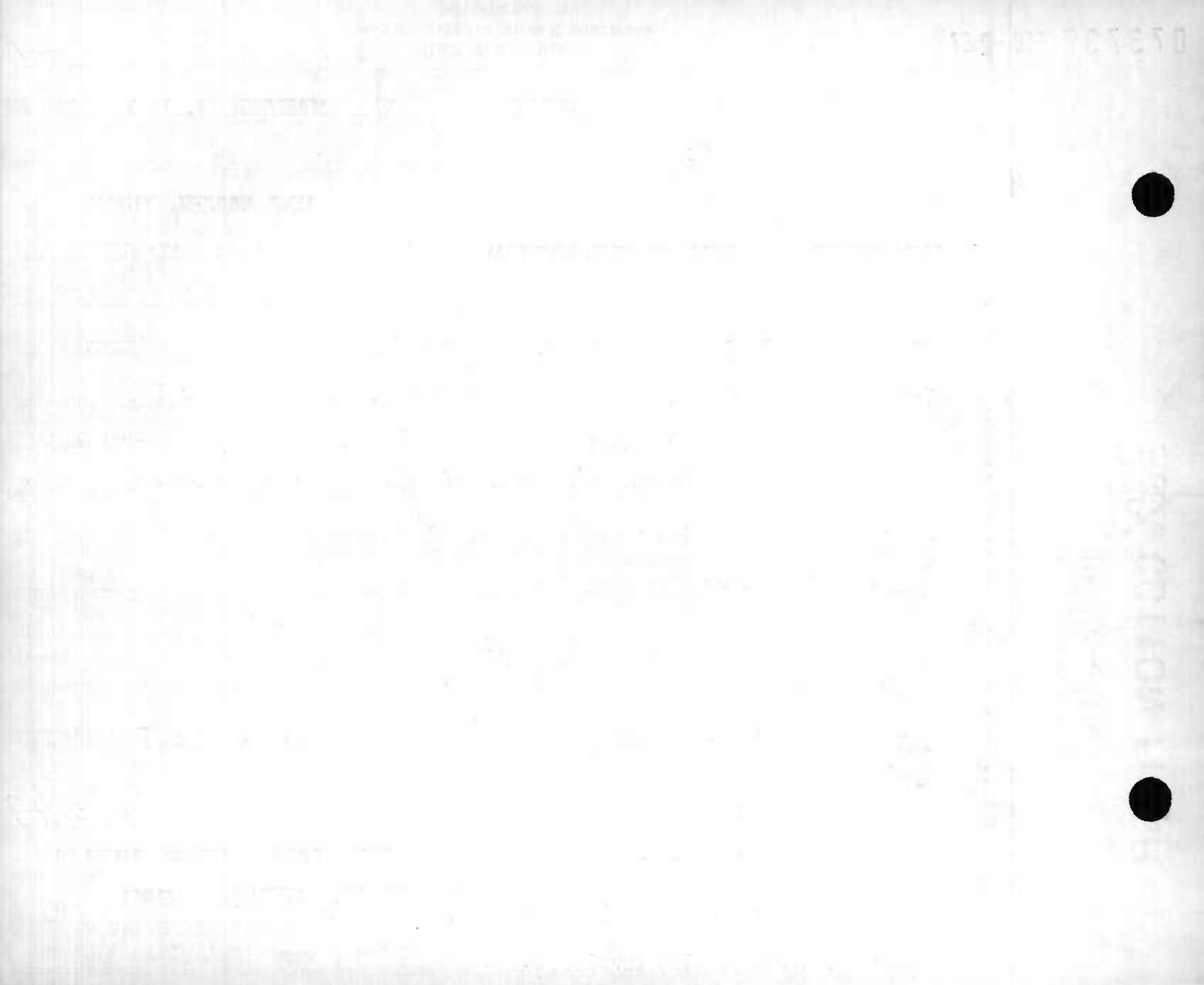
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MELVIN P HEWARD JR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 28 1987</b>		2b. HOUR <b>1245 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 20, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Melvin Paul Heward, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Mabus</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>49</b>		17. INFORMANT ADDRESS <b>Annabelle J. Heward, Same as 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Delayed pleural effusions; congestive heart failure, 10 days</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>End stage renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Diabetes mellitus</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/26 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>Severn AA MD</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>B. Shabazz MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/30/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. SHABAZZ</b>				22e. ADDRESS <b>7231 RITCHIE HIGHWAY SUITE D1</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 2, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLEN BURNIE</b>		23d. LOCATION <b>Glen Burnie AA MD</b>		
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>				
				25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



7 19 16 NOV 16

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 3 0 9 9 4  
REG. NO

1. DECEASED NAME (TYPE OR PRINT) LaRue Park Higgs			2a. DATE OF DEATH MONTH DAY YEAR November 10, 1987			2b. HOUR 1000 P M				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 6 1907		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 993 Indian Landing Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Emp. (Ret)		12b KIND OF BUSINESS OR INDUSTRY Manufacturing		
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 993 Indian Landing Rd. 21108	
14. FATHER'S NAME FIRST MIDDLE LAST Park T. Higgs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Robrage							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO WW II		17 INFORMANT (Wife) Mrs. Olevia L. Higgs		ADDRESS Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-10-87 1000 P M		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>aortic dissection</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>85</u> to <u>11-10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Schmidlein</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-12-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey C. Schmidlein, M.D.			22e. ADDRESS 302 Ritchie Hwy., Severna Park, Md. 21146							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial United Methodist Church		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville A.A. Co. Maryland			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md. 21061			25a. DATE REC'D. BY REGISTRAR NOV 13 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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073417 NOV 30 1987

STATE OF MARYLAND 78745 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8730995	
1. DECEASED NAME (TYPE OR PRINT) Joan H Hill					2a. DATE OF DEATH MONTH DAY YEAR November 10 1987			2b. HOUR 10:10 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 24 1937		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY ANNAPOLIS					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 848 WEST STREET 21401				
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH ORR					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRAGG						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DAVID HASH HR. 39 MADISON PL. ANNAPOLIS MD. 21401							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cardio Pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> , 19 <u>87</u> , to <u>11/10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Victor Plummer</u>					DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor Plummer					22e. ADDRESS 1521 Ritchie Highway Annapolis Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 11-12-87		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN ALEXANDRIA			23d. LOCATION CITY OR TOWN COUNTY STATE FAIRFAX VIRGINIA			
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS					25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

720157 14050

072951 NOV 25 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 00996

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
CHARLES		CLARENCE		Hittel		JR.		11-18-87		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male	White	Nov 4, 1928		59						11-18-87, 2:14P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Anne Arundel County				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		7428 B&A Boulevard		Self Employed		Gun Store					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Anne Arundel		Linthicum		116 Michael Avenue		21090			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Charles C. Hittel, Sr.		Mildred Bach									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		Korean		220.20.9182		Marlene T. Hittel		Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		2:10P 11-18-87		subject shot							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
		gun store		7428 B&A Blvd. Anne Arundel Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)								DATE SIGNED	
<i>Margarita A. Korell</i>		M.D. Assistant MEDICAL EXAMINER								11-19-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Margarita A. Korell, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Nov. 21, 1987		Loudon Park Cemetery		Baltimore Maryland					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Singleton Funeral Home, Glen Burnie, Maryland		NOV 24 1987		<i>Margarita A. Korell</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 38. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

1925 Vol. 1203

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or entombment.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP\_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 0997 EST

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE				87 REG. NO. 30997 EST			
7-61 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
HELEN Catherine HOFFMAN				NOVEMBER 21 1987				145 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		June 12, 1912		75		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Clerk		U.S. Gov't.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Prince Geo.		Upper Marlboro		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13f. STREET ADDRESS			
James S. Yurek				Margaret E. Foltz		11801 Fairgreen Lane, 20772			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		220-34-8543		Phyllis B. Selby, Maryland		20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Flaccid Intracerebral bleed</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Intracranial Arteriovenous Malformation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> 19 <u>87</u> to <u>11/21</u> 19 <u>87</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>11/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. Karipinen</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>11/21/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RANI KARIPINEN, M.D.</u>				22e. ADDRESS <u>200 HOSPITAL DRIVE, SUITE 300 GLEN BURNIE, MARYLAND 21061</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		11-24-87		Arlington Nat'l Cem.		Arlington, Virginia			
24. NAME OF FUNERAL HOME, P. A. OR OTHER PERSON TO WHOM FUNERAL CHARGES ARE TO BE PAID						25. DATE REC'D. BY REGISTRAR			
4739 Baltimore Ave., Hyattsville, Maryland						NOV 25 1987 <u>John D. ...</u>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 3099 EST

1. DECEASED NAME (TYPE OR PRINT) FLORENCE (NMN) HOOPER			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 14, 1987		2b. HOUR 1051 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 16, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 10 Oak Lane W.W. 21061
14. FATHER'S NAME FIRST MIDDLE LAST Joseph MacCraken		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Purkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17. INFORMANT (Cousin) ADDRESS 3511 Horton Ave. Balto., Md. 21225	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI bleed</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ruptured Duodenum Diverticulum.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>87</u> , to <u>11/14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL YOUNG HYMAN, M.D.		22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 108 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. DATE REC'D. BY REGISTRAR NOV 17 1987			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 17 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 30999

1. DECEASED NAME (TYPE OR PRINT) <b>Stephen Boyd Hooper Jr.</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>13</b> YEAR <b>87</b>			2b. HOUR <b>1805</b> M					
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>August</b> DAY <b>19</b> YEAR <b>1971</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>16</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Annapolis</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>13156 Poplar Hill Drive/21401</b>		
14. FATHER'S NAME FIRST <b>Stephen</b> MIDDLE <b>Boyd</b> LAST <b>Hooper, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Kizzie</b> MIDDLE <b></b> LAST <b>Carroll</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-13-1849</b>			17. INFORMANT <b>Stephen Boyd Hooper Sr., Annapolis, MD</b>			18. STREET ADDRESS <b>13156 Poplar Hill Dr.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Motor Vehicle Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RTA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>		
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> MONTH <b></b> DAY <b></b> YEAR <b></b> P.M. <b></b> 19 <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from <b></b> , 19 <b></b> , to <b></b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b></b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas D. Ducker</b>				DEGREE <b></b>		22c. DATE SIGNED <b>Nov. 14, 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas Ducker, M.D.</b>				22e. ADDRESS <b>100 Cathedral St, Annapolis, Md. 21401</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 17, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Tanners Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Page County</b> COUNTY <b>Virginia</b> STATE <b></b>	
24. FUNERAL DIRECTOR NAME <b>Bradley Funeral Home, 187 East Main Street, Luray, Virginia 22835</b>				25a. DATE RECEIVED BY REGISTRAR <b>NOV 19 1987</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exhibited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

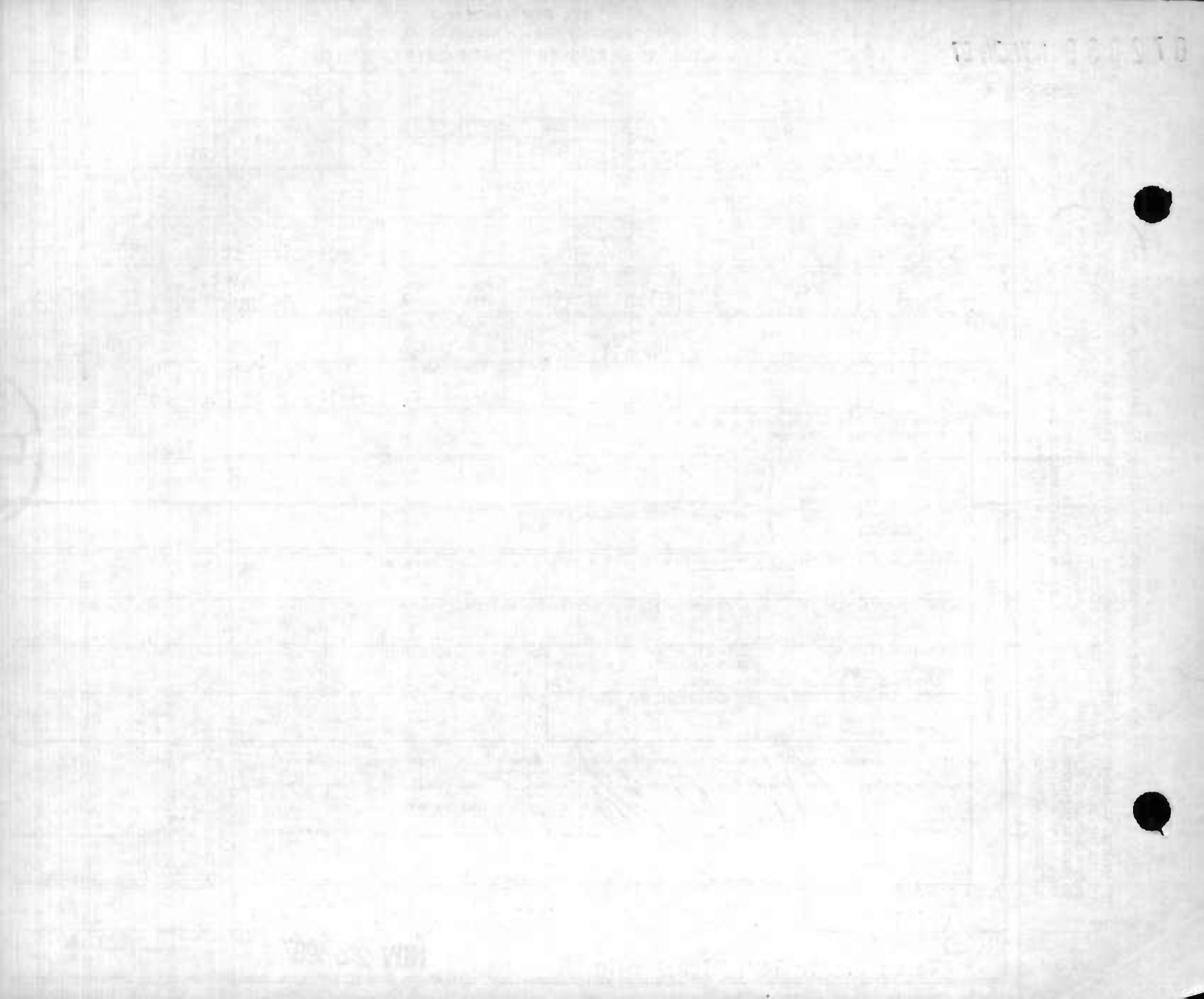
REG. NO. 1 0 0 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Michelle		Howell						11-16-87								8:13P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	June 20, 1967		20 YRS.						11-16		1987					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore		USA				Anne Arundel County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Glen Burnie		North Arundel Hospital		Receptionist		Oil Company											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		Apt. 203							
Maryland		AA		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7972 Nol-Park Court		21061							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
William		Jayne F. O'Hara															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT													
No		218-86-9506		Jayne F. Howell, 1622 Plum Street,													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		P.M. 11-16 1987		Self inflicted													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		home		7972 Nol Park Court, Glen Burnie, Anne Arundel County, Maryland													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Charles P. Kokes, M.D.		Assistant		11-17-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
James S. Kirkley, Glen Burnie, MD		111 Penn Street, Baltimore, MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		Nov. 20, 87		Dulaney Valley Mem. Garden		Baltimore		MD									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
James S. Kirkley, Glen Burnie, MD				NOV 23 1987		Benton-Randall											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates from pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 31001  
REG. NO.

1. FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>VICTORIA</b>		FIRST <b>HRUBES</b>		LAST <b>HRUBES</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-25-87</b>		2b. HOUR <b>9:40 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 20 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AUSTRIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bay Manor Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sewing Factory</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>208 Devon Court 21090</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-10-4774</b>		17. INFORMANT ADDRESS <b>LYNN ACKERMAN 866 DORIS DRIVE 21012</b>					
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease with Cardiac Arrhythmia</b>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-24-84</b> to <b>11-25-87</b> , that (I) (we) last saw the deceased alive on <b>11-11-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>C. V. CYRIAC</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11-25-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. V. CYRIAC, M.D.</b>				22e. ADDRESS <b>14 WELLSHAM AVE, #101 GLENBURNIE, MD 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/27/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John Decker</b>	

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STANDARD

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 31002  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>DORIS MAE HUFF</b>			2a DATE OF DEATH MONTH <b>11</b> DAY <b>19</b> YEAR <b>87</b>			2b HOUR <b>7:35</b> <sup>P</sup>			
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH <b>05</b> DAY <b>17</b> YEAR <b>27</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.			
10 CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8951 Twin Ridge Drive 21061</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKER</b>	
13a STATE <b>MARYLAND</b>		13b COUNTY <b>A.A.</b>		13c CITY OR TOWN <b>Glen burnie</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>8951 Twin Ridge Drive 21061</b>	
14 FATHER'S NAME FIRST <b>ANDREW</b> MIDDLE <b>OLSON</b> LAST <b>STELLA</b>				15 MOTHER'S MAIDEN NAME FIRST <b>STELLA</b> MIDDLE <b>GENCE</b> LAST <b>GENCE</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>219 22 6742</b>		17 INFORMANT <b>Glen Burnie, Maryland 21061</b> <b>Linda M. Phillips 314 Shipley Avenue</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure due to sepsis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Metastatic squamous cell cancer of cervix</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pelvic abscess, sepsis</b>									
19a DATE OF OPERATION _____		19b CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:25 P.M. 11-19 1987</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a I certify that (I) (this hospital) attended the deceased from <b>September 19 87</b> to <b>November 19 87</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 20 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Thomas Gerard DiSalvo</b>				DEGREE <b>MD</b>				22c DATE SIGNED <b>11/20/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas G. DiSalvo</b>				22e ADDRESS <b>600 N. Wolfe St; Johns Hopkins; 21205</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>11/23/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>City</b> STATE <b>Md</b>			
24 FUNERAL DIRECTOR NAME <b>Raymond C. Fink Glen Burnie, Md. 21061</b>				25a DATE REC'D. BY REGISTRAR <b>NOV 20 1987</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>Muriel Carey Huston</b>					2a. DATE OF DEATH MONTH <b>11</b> DAY <b>10</b> YEAR <b>87</b>					2b. HOUR <b>4:00 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>28</b> YEAR <b>1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.			7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Nurse U.S. Navy</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21403 1680 Americana Drive</b>		
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>W</b> LAST <b>Cavey</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Katherine</b> MIDDLE <b>Sullivan</b> LAST <b>van</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1WWT 212387026</b>		17. INFORMANT ADDRESS <b>48 merriion Court</b> <b>Margaret R. Cunningham-Timonium MD 21092</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pharyngeal Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic Ovarian Cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>year</b> <b>year</b> <b>year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Worming</b>											
19a. DATE OF OPERATION <b>11/7</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Worming</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b>19</b> YEAR <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>					
22a. I certify that (1) this hospital attended the deceased from <b>11/7</b> to <b>11/10</b> , 19 <b>87</b> , that (1) (we) lost saw the deceased alive on <b>11/10</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE <b>[Signature]</b> MD					DEGREE <b></b>			22c. DATE SIGNED <b>11/10/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Colgan</b>					22e. ADDRESS <b>703 Giddings Ave. Annapolis Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 16, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN <b>Arlington</b> COUNTY <b>VA</b> STATE <b>VA</b>			
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel-Annapolis, MD</b> ADDRESS <b></b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

BP

is hereby notified that the  
 Department of the Interior  
 has received from the  
 Bureau of Land Management  
 a report of the  
 Survey of the  
 Public Lands of the  
 State of California  
 and the  
 Department of the Interior  
 has determined that the  
 same are  
 subject to the  
 provisions of the  
 Act of March 3, 1879  
 (20 Stat. 391)  
 and the  
 Department of the Interior  
 has determined that the  
 same are  
 subject to the  
 provisions of the  
 Act of March 3, 1879  
 (20 Stat. 391)  
 and the  
 Department of the Interior  
 has determined that the  
 same are  
 subject to the  
 provisions of the  
 Act of March 3, 1879  
 (20 Stat. 391)



071155 NOV - 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 31004  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>TheLma M. Hutton</b>			2a DATE OF DEATH MONTH <b>11</b> DAY <b>2</b> YEAR <b>87</b>		2b HOUR <b>9:21 AM</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH <b>NOVEMBER</b> DAY <b>8</b> YEAR <b>1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10 CITY OR TOWN OF DEATH <b>CROFTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CROFTON CONVELESENT CENTER</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b KIND OF BUSINESS OR INDUSTRY <b>FACTORY</b>
13a STATE <b>MARYLAND</b>			13b COUNTY <b>ANNE ARUNDEL</b>	13c CITY OR TOWN <b>PASADENA</b>	
14 FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b></b> LAST <b>BOWEN</b>			15 MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b></b> LAST <b>WEISMAN</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>217 01 2266</b>		17 INFORMANT ADDRESS <b>3382 OCEAN PINES BERLIN, MD 21811</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardio-Vasc. Ax</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Senile Dementia</b>					
19a DATE OF OPERATION <b>Nov 2</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>Dec 1</b> , 19 <b>85</b> , to <b>Nov 2</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Aug 1</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Barry R. Nathanson MD</b>				22c DATE SIGNED <b>11/3/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY R. NATHANSON MD</b>				22e ADDRESS <b>51 FRANKLIN ST ANNAP MD 21401</b>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>Nov. 6, 1987</b>		23c NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN MEM. PK.</b>	
23d LOCATION CITY OR TOWN <b>GLEN BURNIE</b>		COUNTY <b>ANNE ARUNDEL</b>		STATE <b>MD</b>	
24 FUNERAL DIRECTOR NAME <b>McCULLY FUNERAL HOME</b>		ADDRESS <b>3204 MOUNTAIN RD PASADENA, MD 21122</b>		25a DATE REC'D. BY REGISTRAR <b>NOV 6 1987</b>	
25b REGISTRAR'S SIGNATURE <b>Barry R. Nathanson</b>					

For the purpose of this report, the following information was obtained from the records of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation, regarding the land ownership and management of the area described in the title of this report.

The land ownership and management of the area described in the title of this report is as follows:

1. The land is owned by the United States of America, Department of the Interior, Bureau of Land Management.

2. The land is managed by the Bureau of Land Management, which is responsible for the conservation and management of the land resources of the United States.

3. The land is located in the State of California, County of [County Name], and is situated within the [Area Name] area.

4. The land is currently being used for [Use Description] purposes.

5. The land is subject to the following conditions:

- [Condition 1]
- [Condition 2]
- [Condition 3]

This report was prepared by [Author Name] on [Date] and is intended to provide information regarding the land ownership and management of the area described in the title of this report.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31005 EST

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
GARY Manakee JOHNSON		NOVEMBER 19, 1987		5.31 AM	
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	Dec. 2, 1935	51	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	USA			ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Video Sales		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Anne Arundel	Linthicum	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	105 Homewood Road 21090	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
John Manakee Johnson		Estelle M. White		16b. SOCIAL SECURITY NO. 215-32-5735	
17. INFORMANT		17. ADDRESS			
Miss Sandra W. Johnson		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) M.I.					1 hour
DUE TO, OR AS A CONSEQUENCE OF (b) C.A.D.					2 Years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 11/18, 1987, to 11/19, 1987, that (1) (we) last saw the deceased alive on 11/19, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) saw the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
7845 OAKWOOD ROAD, SUITE 200				GLEN BURNIE, MARYLAND 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. STATE
Burial		Nov. 23, 1987	Parkwood	Baltimore	Maryland
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		
NAME Leonard J. Ruck Inc. Baltimore, Maryland			NOV 23 1987		
ADDRESS			25b. REGISTRAR'S SIGNATURE		
			Julia Dodson-Rodner		

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician, and that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

074094 DEC

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		SR		
WILBUR			FULTON		JONES						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH		7b. HOUR	
MALE		BLACK		MONTH DAY YEAR 09 26 1902		85 YRS.		NOVEMBER 22, 1987		0505 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U. S. A.				ANNE ARUNDEL COUNTY		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL								General Contractor Employed	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		A.A. Co.		Severn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		609 Jones Road. Severn, Md.		21144	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST John B. Jones			FIRST MIDDLE LAST Minerva Williams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
No.			220-07-3832-A			Mrs. Helen A. Jones 609 Jones Road, Severn, Md. 21144					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>a cure pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>Nov. 8, 1987</u> , to <u>Nov. 22, 1987</u> , that (1) (we) last saw the deceased alive on <u>Nov. 21, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE REC'D. BY REGISTRAR			22g. REGISTRAR'S SIGNATURE		
CHARLES J. WU, M.D.			7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061			DEC 03 1987			Julia Dandrea-Randall		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			11/28/1987		Arbutus Memorial Park		Baltimore, Maryland				
24. FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216						DEC 03 1987		Julia Dandrea-Randall			

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073206 NOV 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31007

1. DECEASED NAME (TYPE OR PRINT) <b>KATHERINE L. JOLIFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 18 87</b>		2b. HOUR <b>0300 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 12 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ASHLEY PENNSYLVANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>EDGEWATER</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>191 CARDAMON DRIVE</b>		12a. USUAL OCCUPATION (IF NOT WORKING, GIVE OTHER WORKING INDUSTRY) <b>LOGISTICS MANAGER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AIR FORCE CIVIL SERVICE</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>EDGEWATER</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY LONG STAIR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLA MAY WARD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>206-18-4762</b>	17. INFORMANT ADDRESS <b>JAMES V. JOLLIFF SAME AS 13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO Resp arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Mitral Stenosis Occasioned</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>COPD, Sp resection of distal esophagus 1977</b>					
19a. DATE OF OPERATION <b>11-2-87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COPD</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>10</b> 19 <b>87</b> , to <b>11-18</b> 19 <b>87</b> , that (2) (we) last saw the deceased alive on <b>11-2-87</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Do not sign and do not view the body after death.)					
22b. SIGNATURE <b>Michael J. Lapenta</b>			DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL J. LAPENTA</b>			22e. ADDRESS <b>703 GIDDINGS AVE ANNAPOLIS Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-21-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKEMONT DAVIDSONVILLE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNE ARUNDEL MD.</b>
24. FUNERAL DIRECTOR <b>ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS, MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1987</b>		

MEDICAL CERTIFICATION

75 60 35 020 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be placed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
071851 NOV 18 87									
REG. NO. 87 31008									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR T JONES, Sr						2a. DATE OF DEATH MONTH DAY YEAR 11 13 87		2b. HOUR 3:20 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 25, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 527 Burnside Street 21403	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Oley Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Catterton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 217-24-0534		17. INFORMANT ADDRESS Marie Q Jones- Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/9 to 11/13, 1987, that (I) (we) last saw the deceased alive on 11/13, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E W Cole III				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III				22e. ADDRESS 51 FRANKLIN ST ANNAP MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov. 16, 1987		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel- Annapolis, MD				25a. DATE REC'D. BY REGISTRAR NOV 13 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31009 EST

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 26, 1987</b>		2b. HOUR <b>1050 AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10/29/1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>A. A. Co.</b>	13c. CITY OR TOWN <b>Linthicum</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eustace McQuay</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Murphy</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>219-16-6749</b>		17. INFORMANT ADDRESS <b>William J. Jones, Jr. Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Lung Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? 3 MOS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Rapid Alkal Fibrinolysis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 10, 19 87</b> , to <b>NOV 27, 19 87</b> , that (I) (we) last saw the deceased alive on <b>NOV 27, 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Lawrence P. Swink</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-26-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE P. SWINK, M.D.</b>		22e. ADDRESS <b>4191 MOUNTAIN ROAD PASADENA, MARYLAND 21122</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/28/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland A. A. Co.</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes Balto., Md. 21225</b>		24b. ADDRESS <b>237 E. Patapsco Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>	
		25b. REGISTRAR'S SIGNATURE <b>Julia Tindan-Randall</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DATE: 10-1-73

10-1-73

JOHN WARRIOR, COUNTY

JOHN WARRIOR, HOSPITAL

JOHN WARRIOR

JOHN WARRIOR

RECEIVED

DEC 01 1973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST <b>MICHAEL E JUDGE</b>									
2a DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 07, 1987</b>									
2b HOUR <b>0805 AM</b>									
3 SEX <b>Male</b>									
4 RACE <b>Caucasion</b>									
5. DATE OF BIRTH MONTH DAY YEAR <b>3-10-1939</b>									
6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b>									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>									
7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>									
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>									
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>									
12b KIND OF BUSINESS OR INDUSTRY <b>-----</b>									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>									
13b COUNTY <b>A.A. Co.</b>									
13c CITY OR TOWN <b>Annapolis</b>									
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13e STREET ADDRESS / ZIP CODE <b>605 Beach Dr Annapolis 21403</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis M. Judge</b>									
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Suzanne F. Judge</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>									
16b SOCIAL SECURITY NO. <b>219-76-4732</b>									
17. INFORMANT ADDRESS <b>Francis M. Judge (Same as above 13e)</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>rupture</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>rupture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>Respiratory failure secondary to cerebral aneurysm</b>									
19a DATE OF OPERATION <b>11-10-1987</b>									
19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>rupture of cerebral aneurysm</b>									
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)									
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>									
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK									
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from <b>total</b> 19 <b>87</b> , to <b>11/7</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11/7</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE DEGREE <b>Robert B. Kroopnick, M.D.</b>									
22c DATE SIGNED <b>11/10/87</b>									
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. KROOPNICK, M.D.</b>									
22e ADDRESS <b>95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>									
23b DATE <b>11-10-1987</b>									
23c NAME OF CEMETERY OR CREMATORY <b>Lakemont Cem.</b>									
23d LOCATION CITY OR TOWN COUNTY STATE <b>Davidsonville A.A. MD</b>									
24 FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCO</b>									
25 DATE RECEIVED BY REGISTRAR <b>NOV 12 1987</b>									
25b REGISTRAR'S SIGNATURE <b>JIM</b>									

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071591 NOV 13 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 3 1 0 1 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KARL KAUKO KAINU</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 / 7 / 1987</b>		2b. HOUR <b>3:00PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/23/1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS MONTHS DAYS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RED LODGE, MONT.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDREL MD.</b>		
10. CITY OR TOWN OF DEATH <b>CROFTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1404 Ormsby Place</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARPENTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A A</b>		13c. CITY OR TOWN <b>CROFTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>1404 Ormsby Place</b>		13f. STREET ADDRESS <b>21114</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>JALO - KAINU</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OLGA - BETALA</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>182-09-6903</b>		17. INFORMANT ADDRESS <b>ROBERT KAINU - SON 1404 ORMSBY CROFTON, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ALZHEIMERS DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PARKINSONS DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>5 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PARKINSONS DISEASE</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 1983</b> to <b>NOV 7 1987</b> , that (I) (we) last saw the deceased alive on <b>NOV 2 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <b>Norman K. Bohrer MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>Nov 9, 1987</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NORMAN K. BOHRER, MD</b>		
22e. ADDRESS <b>3231 SUPERIOR LANE BOWIE, MD 20715</b>		22f. ADDRESS <b>3231 SUPERIOR LANE BOWIE, MD 20715</b>		22g. ADDRESS <b>3231 SUPERIOR LANE BOWIE, MD 20715</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/10/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		ADDRESS <b>6160 Oxon Hill Rd Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as not applicable, any injury or other traumatic event, the medical examiner must be notified.

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 31012 REG. NO.			
1. FOR STATE REGISTRAR										20. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P	
18-07 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis A. Kellenberger										November 12, 1987		1:15 AM	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 4, 1888			6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD				
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Main Avenue, S.W.							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Clerk		12b. KIND OF BUSINESS OR INDUSTRY B & O RR	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 101 Main Avenue, S.W. 21061				
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Kellenberger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Martin								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 705-05-3000		17. INFORMANT ADDRESS Dale R. Kellenberger, 1413 Bolton Street, Baltimore, MD 21217						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure, CVA</u> (b) <u>Ischemic Heart Disease</u> (c) <u>Due to, or as a consequence of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1938</u> , 19____, to <u>Nov 12</u> , 19 <u>1987</u> , that (I) (we) last saw the deceased alive on <u>11/9/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Andrew R. Sosnowski</u>						DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/13/87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew R. Sosnowski, M. D.						22e. ADDRESS 4016 Ritchie Highway, Baltimore 21225							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 16, 87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD					
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rudner</u>					



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31013

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				3. DATE OF DEATH				4. HOUR			
THELMA MARIE KELLEY				11-11-87				11-11-87				9:38 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 24 HRS.		8. DATE OF DEATH		9. DATE OF DEATH			
Female		White		June 16 1921		66 YRS.		MONTHS DAYS HOURS MIN.		November 11-11-87		9:38 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia				U.S.A.								ANNE ARUNDEL COUNTY			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie				North Arundel Hospital				Housewife				Own Home			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				A.A. Co.				Linthicum				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. STREET ADDRESS				17. CITY OR TOWN			
Emmett				Shirley				Bethel				Nesmith			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				18b. SOCIAL SECURITY NO.				19. INFORMANT (Husband)				ADDRESS			
No				N/A				235.18.7611				Delbert R. Kelley Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Margarita A. Korell, M.D.				Assistant				11-12-87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Korell, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				Nov 16 1987				United Methodist Church Greenwood Cemetery				Berkeley, Morgan, W. Virginia			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Singleton Funeral Home, Glen Burnie, Md.				NOV 17 1987											

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT - PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31014

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
DECEASED NAME (TYPE OR PRINT) <b>IDA - KILMON</b>			<b>NOVEMBER 17 1987</b>			<b>920 AM</b>		
3 SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 3 1902</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84 YRS.</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1228 Hillside Rd. 21122</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Dunkle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Howard</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>220 05 3173A</b>		17. INFORMANT ADDRESS <b>Thomas H. Kilmon (same as 13E)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probable myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>history Parkinson's disease</b>								
19a. DATE OF OPERATION <b>August 21, 87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>August 21, 87</b> to <b>November 17, 1987</b> , that (I) (we) last saw the deceased alive on <b>November 17, 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>James D. Sparkes, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-17-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>3708 MOUNTAIN ROAD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>11/19/87</b>		23c. NAME OF CEMETERY <b>PASADENA, MARYLAND</b>		23d. ADDRESS <b>21122</b>		23e. COUNTY <b>A.A.</b> STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy. Baltimore Md. 21225</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>	

MEDICAL CERTIFICATION

7 2 0 0 1 0 0 3 0 1

MAILED 17 1967 100 100

EXHIBIT

100

WASH. AIRPORT

INTERNATIONAL TERMINAL

100 100

3700 UNIVERSITY ROAD

WASHINGTON, D.C. 20007

100 100



1- FOR  
2- STATE  
3- REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1015

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
JACOB		LOUIS		KORN				11		11		19		87							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE		MONTH		DAY		YEAR			
M		Cauc		01 14 20		67 YRS.		MONTHS		DAYS		HOURS		MIN.		11		11			
7a. BIRTHPLACE (STATE OR TERRITORY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY		2d. HOUR			
Virginia		USA		WIDOWED		X		DIVORCED		AA		Annapolis		Anne Arundel Gen		Retired		2300			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Md		AA		Edgewater		YES		NO		Michael		Katherine C		Bladt		21401		Mary Troutman			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		22. (b)		23. DUE TO, OR AS A CONSEQUENCE OF		24. (c)		25. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED?		28. AUTOPSY?	
Cardiac Arrest		Cardiac Arrest		Cardiac Arrest		Cardiac Arrest		Cardiac Arrest		Cardiac Arrest		Cardiac Arrest		Lung Cancer		YES		NO		X	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL CAUSE WAS		30. TIME OF INJURY		31. HOW INJURY OCCURRED		32. PLACE OF INJURY		33. LOCATION		34. I certify that I took charge of the remains described above, held an		35. Autopsy		36. Inspection		37. Inquiry		38. and in my opinion		39. death resulted from:	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Natural causes		X		Accident		Suicide		Homicide		Undetermined manner	
29. EXTERNAL																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827,

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 1016

1. DECEASED NAME (TYPE OR PRINT) <i>Edward Kravets</i>			2a. DATE OF DEATH MONTH <i>11</i> DAY <i>14</i> YEAR <i>87</i>		2b. HOUR <i>10</i> <i>00</i> P.M.
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>5</i> DAY <i>1</i> YEAR <i>27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Edgewater</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pleasant Living Conv. Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF LIVING) <i>Ret. Police</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>D, C, Police</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Md</i>	13b. COUNTY <i>A.A. Co.</i>	13c. CITY OR TOWN <i>Edgewater</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>925 Shore Dr 21037</i>	
14. FATHER'S NAME FIRST <i>Andrew</i> MIDDLE LAST <i>Kravets</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE LAST <i>Dulcis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <i>WW 11</i>		17. INFORMANT ADDRESS <i>Evelyn McCutcheon Edgewater Md. 2103</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accident.</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/8</i> 19 <i>87</i> , to <i>11/14</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>11/16</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>R.B. Hall M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/15/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>11-16-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>		23d. LOCATION <i>Leckrone</i> COUNTY <i>Pa.</i> STATE
24. FUNERAL DIRECTOR NAME <i>T.A. Hardesty</i> ADDRESS <i>Annapolis Md. 21401</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 20 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John Andrew Rindell</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove extemporaneous pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
073113 NOV 25 1987		FOR STATE REGISTRAR <u>ANNA M.</u>		REG. NO. <u>87 31017</u>					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>ANNA M. LACE</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>11/12/87</u>		2b. HOUR <u>630</u> P.M.			
3. SEX <u>FEMALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>11-30-07</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <u>79</u>		IF UNDER 1 YEAR IF UNDER 72 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE ARUNDEL CO. MD.</u>			
10. CITY OR TOWN OF DEATH <u>ANNAPOLIS</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ANNE ARUNDEL GEN. HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Chief operator</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>C&amp;P Telephone</u>	
13a. STATE <u>MARYLAND</u>				13b. COUNTY <u>ANNE ARUNDEL</u>		13c. CITY OR TOWN <u>SEVERNA PARK</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>JAMES J. LACE</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>FRANCES BONIRSKI</u>		13e. STREET ADDRESS <u>734 Tidewater Ave / 21146</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>212-05-1122</u>		17. INFORMANT ADDRESS <u>Col. Patricia May 5733 Thunder Hill Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN ANOXIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 5 min</u> <u>~ 5 min</u> <u>~ 1-2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Aortic Stenosis, Mitral Regurg., CAD, ASVD, NIDDM Renal Failure, UTI, ...</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> 19 <u>87</u> , to <u>11/12</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/12/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ANDREW GORDON MD</u>				22e. ADDRESS <u>16 Murray Ave Annapolis Md 21401</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11-16-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE CITY, MD</u>			
24. FUNERAL DIRECTOR NAME <u>BARRANCO SEVERNA PARK</u>				ADDRESS <u>MD 21146</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 17 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

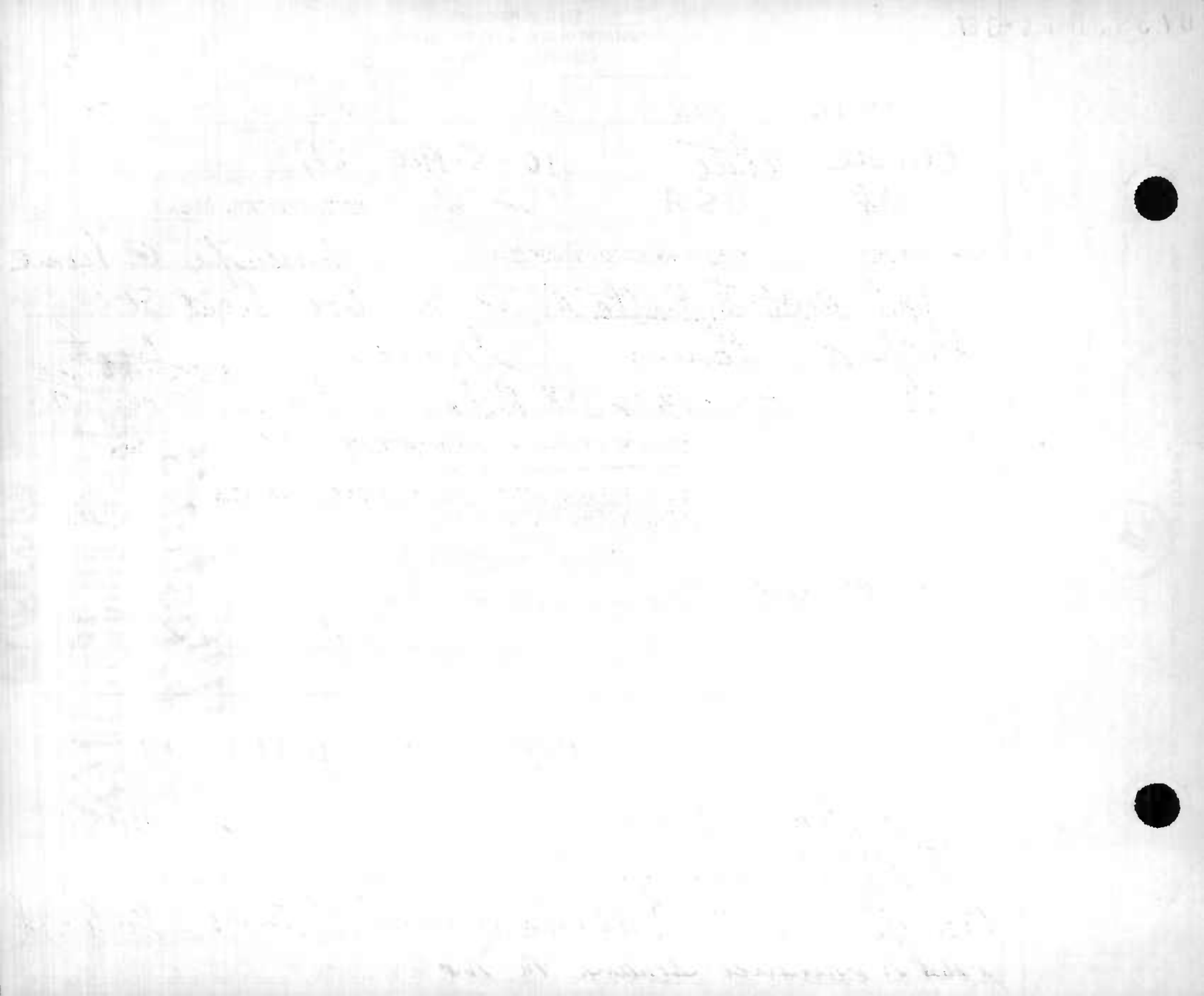
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event (the medical examiner may be notified at once).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 31018		EST	
1. DECEASED NAME (TYPE OR PRINT) MILDRED EMMA LANG					2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 18, 1987				2b. HOUR P M 7:19				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-5-1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
12. CITY OR TOWN OF DEATH GLEN BURNIE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				14a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			14b. KIND OF BUSINESS OR INDUSTRY @ home				
15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15b. STATE MD		15c. COUNTRY Baltimore		15d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15e. STREET ADDRESS 600 Light St.			15f. ZIP CODE 21230				
16a. FATHER'S NAME FIRST MIDDLE LAST Richard Lewis				16b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Smith				16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
17a. SOCIAL SECURITY NO. 213 365538				17b. INFORMANT Richard C. Lang				17c. ADDRESS 35 SEVERNA DRIVE SEVERNA PK.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY INSUFFICIENCY 911 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE HEMORRHAGIC ENTERITIS WITH POSSIBLE INFARCTION SMALL BOWEL DUE TO, OR AS A CONSEQUENCE OF (c) FEW HOURS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a ASPIRATION OF GI CONTENTS													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-18, 19 87, to 11-18, 19 87, that (I) (we) lost saw the deceased alive on 11-18-19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Signature Below				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/18/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TELESFORO G. REYES, JR., M.D.				22e. ADDRESS 301 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 11-20-87		23c. NAME OF CEMETERY OR CREMATORY Westman-Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD					
24. FUNERAL DIRECTOR Signature				24b. ADDRESS Signature				25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE Signature			

BP





261  
DECEASED NAME  
(TYPE OR PRINT)

261  
DECEASED NAME  
(TYPE OR PRINT)

261  
DECEASED NAME  
(TYPE OR PRINT)

[illegible]

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
VR A15 ME (5))

071171 101201

NOV 19 1954

NOV 19 1954

NOV 19 1954

Mr. [illegible]

Robert Lee Lewis

X 11 0 23

X 11 0 23

A.B.

7333 Telegraph Rd

7333 Telegraph Rd

Charles [illegible]

Hepburn & Associates, Denver

X

X

Deputy

was furnished by [illegible]

NOV 19 1954

071799 NOV 13 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31020 EST

1. DECEASED NAME (TYPE OR PRINT) <b>EDUARD LOO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 07, 1987</b>			2b. HOUR <b>600 PM</b>					
3. SEX <b>Male</b>		4. RACE <b>Caucasion</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 9, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Estonia, Europe</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Estonia, Europe</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Educator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School System</b>			
13a. STATE <b>Maryland</b>					13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Juuli</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>331-28-7623</b>		17. INFORMANT ADDRESS <b>Maila Koiva 693 Dill Rd. Severna Park 21146</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OBSTRUCTIVE UROPATHY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>EMPHYSEMA, ANEMIA</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> , 19 <b>87</b> , to <b>11/7</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/7</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>S. Munder</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>11/8/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SURYA P. MINDRA, M.D.</b>					22e. ADDRESS <b>203 E. PATAPSCO AVENUE BALTIMORE, MARYLAND 21225</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11-10-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. CITY OR TOWN <b>Westview, Balt</b>		23e. COUNTY <b>MD</b>		
24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANGO</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>					25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randner</b>	

BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

071798 NOV 13 67

121

THURSDAY

100

NOVEMBER 07, 1967 600 PM

WIDE ANGLE COUNTRY

CLUB MEMBERS NORTH AVENUE HOSPITAL

RECEIVED

SERVA P. MERRILL, M.D.

203 E. PATASCO AVENUE  
BALTIMORE, MARYLAND 21215

ROBERT S. BARRANG

SEVERNA PARK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholder's Page 1 and 3 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31021

1. DECEASED NAME (TYPE OR PRINT) <b>Edward F. Lowell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 17 87</b>			2b. HOUR <b>9<sup>30</sup> AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 19 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto. Tires</b>	
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Anne Arundel</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>912 Topmast Way</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick H. Lowell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary T. Sweeny</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II</b>		17. INFORMANT <b>Ruth A. Barry</b>		ADDRESS <b>as in item 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Block - Complete</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Myocardial Infarction</b>								<b>hours</b>	
DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Severe coronary artery disease</b>								<b>Yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> 19 <b>87</b> , to <b>11/17</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gregory Mitchell</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory Mitchell</b>						22e. ADDRESS <b>205 Ridgely Ave. Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-20-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.G. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>			

*Julia Denton-Rucker*



72023  
2023 NOV 17 871- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31022

1. DECEASED NAME (TYPE OR PRINT) Louis Edward Lueders, Sr.			2a. DATE OF DEATH MONTH DAY YEAR November 12, 1987		2b. HOUR 6:05 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Trucking
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md. A.A.		13b. CITY OR TOWN Crownsville	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 1012 Generals Hwy. 21032	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Lueders, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ottilia Leaf		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956-1959	17. INFORMANT ADDRESS Mary Anne Lueders same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>resp failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>L Schuchter MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lynn Schuchter</u>		22e. ADDRESS <u>Johns Hopkins</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/15/87	23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.
24. FUNERAL DIRECTOR NAME Fleck Funeral Home Inc.		7601 Sandy Spring Rd. ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 16 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked, item 18 shows autopsy, or other traumatic event, the medical examiner must be notified at once.

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Phone: [illegible]  
7. Email: [illegible]  
8. Date: [illegible]  
9. Signature: [illegible]  
10. Title: [illegible]

*Handwritten notes:*  
[illegible]  
[illegible]

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Phone: [illegible]  
7. Email: [illegible]  
8. Date: [illegible]  
9. Signature: [illegible]  
10. Title: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WILLIAM Beall		MACHANDE		11-7-87		645 P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male	White	01 26 1938		49 56 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA				ANNE ARUNDEL CO. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS	ANNE ARUNDEL GENERAL HOSP			Carpenter		Contractor	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		
Maryland		Anne Arundel	Davidsonville		2406 Rutland Road 21035		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Frank Machande				Bertie Beall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
YES		1957-1959		220-36-6187 Katherine H. Machande 39 Franklin Street Annapolis, MD 21401			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE Brain hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>87</u> , to <u>11/7</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/7</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <u>Thomas Walsh</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-9-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS WALSH MD</u>				22e. ADDRESS <u>RIVER REACH MEDICAL CTR Severna Park Md 21446</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		NOV 10, 1987		Lakemont Memorial Gdns		Davidsonville, Anne Arundel MD	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Beall Funeral Home				NOV 13 1987		<u>John B. ...</u>	

11 OCT NOV 1967

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "is" are visible.]*

*[Faint text at the bottom of the page, possibly a footer or additional bleed-through.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 7 3 1 0 2 4 REG. NO. EST				
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JOHN MAHLE					2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 30 1987			2b. HOUR 1135 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 19, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY National Brewery	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7501 A Furnace Branch Rd. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST (UNKNOWN) Mahle					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie (UNKNOWN)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17. INFORMANT (Wife) Marie M. Mahle		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30</u> 19 <u>87</u> , to <u>Nov. 30</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Nov. 30</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles J. Wu, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Nov. 30, 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU, M.D.				22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec 1, 1987		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME R. A. Hyskin				ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 03 1987		25b. REGISTRAR'S SIGNATURE Julia D. Anderson	

071007 100-30

RECEIVED BY THE SECRETARY OF THE ARMY

THE SECRETARY OF THE ARMY  
WASHINGTON, D.C.

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

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WASHINGTON, D.C.

DEC 03 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 31025  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther R. Marsden			2a. DATE OF DEATH MONTH DAY YEAR 11 22 87			2b. HOUR 6 <sup>00</sup> A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 24, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AnnArundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Sect.		12b. KIND OF BUSINESS OR INDUSTRY Profess. News Service	
13a. STATE Maryland		13b. COUNTY Ann Arundel		13c. CITY OR TOWN Harwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST H. Ambrose Marsden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie T. Whelan		13e. STREET ADDRESS 3625 Solomons Island Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-2078		17. INFORMANT ADDRESS Edmund T. Fridrich (Bro.-in-Law) same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe atherosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Yrs</u> <u>Yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i.e.) <u>1) S/P amputation - leg 2) COPD</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>86</u> to <u>11/22</u> , 19 <u>87</u> , that (2) I saw the deceased alive on <u>11/11</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (3) I (we) did not view the body after death.							
22b. SIGNATURE <u>George C. Samaras MD.</u>				DEGREE <u>MD</u> ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/24/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George C. Samaras</u>				22e. ADDRESS <u>205 Ridgely Ave Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 25, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME <u>John P. DeVol</u> DeVol Funeral Home 2222 Wisc. Ave., NW Wash. DC				25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>John P. DeVol</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

07.3366

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8731026  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Hazel MIDDLE: Freda LAST: Martin			2a. DATE OF DEATH MONTH: November DAY: 24 YEAR: 1987			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH: April DAY: 8 YEAR: 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS: _____ DAYS: _____	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
12. CITY OR TOWN OF DEATH Glen Burnie		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8933 Twin Ridge Road				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		15. KIND OF BUSINESS OR INDUSTRY Own Home	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland 13b. COUNTY: Anne Arundel 13c. CITY OR TOWN: Glen Burnie			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 8933 Twin Ridge Rd. 21061				
19. FATHER'S NAME FIRST: Arnold MIDDLE: H. LAST: Norris			20. MOTHER'S MAIDEN NAME FIRST: Amelia MIDDLE: _____ LAST: Schleuter						
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			21b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		22. INFORMANT (Granddaughter) Mrs. Kathleen L. Gray Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> DUETO, OR AS A CONSEQUENCE OF (b) <u>Hypertension Aseptic.</u> DUETO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET: _____ CITY OR TOWN: _____ COUNTY: _____ STATE: _____				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-6-87</u> , 19____, to <u>11-24-87</u> , 19____, that (I) (we) lost saw the deceased alive on <u>11-25-87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George Angov</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/24/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George Angov					22e. ADDRESS 3350 Wilkins Ave. Balto, Md. 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN: Baltimore COUNTY: Balto. STATE: Maryland		
24. FUNERAL DIRECTOR NAME: <u>P. H. Hyatt</u> Singleton Funeral Home, Glen Burnie, Md. 21061					25a. DATE REC'D. BY REGISTRAR NOV 27 1987		25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>		

MEDICAL CERTIFICATION

BP \_\_\_\_\_

100-02-00000



San Francisco

Dear Mr. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other", the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8731027 EST

FOR  
1. STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>CHARLES Lewis MARVEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 28, 1987</b>			2b. HOUR <b>035 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 4, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Map Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hoen Co.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Albert Marvel</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Peusch</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT (Sister) ADDRESS <b>Mildred Fisher Erdenheim, Pa. 19118</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA RIGHT KIDNEY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNG METASTASIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>										
19a. DATE OF OPERATION <b>11/25/87</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Right CA. Kidney</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/17/87</b> , 19____, to <b>11/28</b> , 19____, that (I) (we) lost saw the deceased alive on <b>11/28/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Victor Salama</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/29/87</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VICTOR SALAMA, M.D.</b>					22e. ADDRESS <b>95 AQUAHART ROAD GLEN BURNIE, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 2, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Co. Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Singleton Funeral Home, Glen Burnie, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>		25b. REGISTRAR'S SIGNATURE		

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UNIT 1000

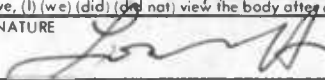
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073083 NOV 25 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 31028 EST  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KENNARD (ASA) A. MATTHEWS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 20, 1987</b>			2b. HOUR <b>9:37 PM</b>				
3. SEX <b>male</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 17 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>352 Addison Drive 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin H. Matthews</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Nicholson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-16-9005</b>		17. INFORMANT <b>Dolores H. Matthews</b>		ADDRESS <b>352 Addison Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive crisis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>1 day</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Subendocardial Myocardial Infarction</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-13</b> , 19 <b>87</b> , to <b>11-20</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11-20</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11-20-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LONG S. HSU, M.D.</b>			22e. ADDRESS <b>300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/25/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Rest Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harmons Md</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West 4300 Wabash Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 7 as showing any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 1 0 3 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE		FIRST M.		MIDDLE M.		LAST McCLANAHAN		2a. DATE OF DEATH MONTH DAY YEAR November 26, 1987		2b. HOUR 7:00 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 16, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner-mgr.		12b. KIND OF BUSINESS OR INDUSTRY Upholstery			
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1113 N. Skyway Dr. /21401			
14. FATHER'S NAME FIRST MIDDLE LAST John E. Wood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Mrs. Kimberly McClanahan (same as 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) acute MI DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. D. Goldstein MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-27-1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. D. Goldstein MD.				22e. ADDRESS 205 Ridgely Ave. Annapolis, Md. 21401							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-28-1987		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md.					
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO ADDRESS SEVERNA PARK, MD. 21146				25a. DATE REC'D BY REGISTRAR DEC 01 1987		25b. REGISTRAR'S SIGNATURE					

BP.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31029

1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice V Maxwell</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-3-87</b>		2b. HOUR <b>7<sup>00</sup> AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 16 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE COUNTRY STATE OR FOREIGN <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meredian Convalescent Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST =====		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST =====			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>161-09-8920</b>		17. INFORMANT ADDRESS <b>Jack Maxwell Same as 13c</b>	

18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**Respiratory Cardiac failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **terminal renal failure**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) **congestive heart failure**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Senile dementia of Alzheimer type**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> 19 <b>87</b> to <b>11/3</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>[Signature]</b>	DEGREE <b>[Signature]</b>		22c. DATE SIGNED <b>11/3/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HO-LAI FENG</b>		22e. ADDRESS <b>5515 Ritchie Highway Balto MD 21225</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/5/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md</b>
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1987</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with (in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD J MCGUIRE SR</b>					2a. DATE OF DEATH MONTH <b>NOVEMBER</b> DAY <b>2</b> YEAR <b>1987</b>			2b. HOUR <b>535 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>04</b> DAY <b>15</b> YEAR <b>22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steamfitter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>JAMES</b> MIDDLE <b></b> LAST <b>McGuire</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Lillian</b> MIDDLE <b></b> LAST <b>Gurlock</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>					16b. SOCIAL SECURITY NO. <b>WW 11 214 16 3572</b>		17. INFORMANT <b>Glen Burnie, Maryland 21061</b> <b>Anna L. McGuire 1216 Leonard Drive</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Ischemic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/21/87</u> to <u>11/2/87</u> , that (I) (we) lost saw the deceased alive on <u>11/1/87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE <u>Robert B. Kroopnick</u>					DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			27c. DATE SIGNED <u>11/2/87</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. KROOPNICK, M.D.</b>					27e. ADDRESS <b>95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/5/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Park</b>		23d. LOCATION CITY OR TOWN <b>Glen Burnie A.A.</b> COUNTY <b>MD</b> STATE <b></b>		
24. FUNERAL DIRECTOR NAME <b>Raymond C. Fink</b> ADDRESS <b>Glen Burnie, Md. 21061</b>					25a. DATE REC'D BY REGISTRAR <b>NOV 03 1987</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>		

1. NAME: JANE WARDEN DOWDY  
2. ADDRESS: 1000 10th St, N  
3. CITY: NORTH WINDHAM, WISCONSIN  
4. STATE: WISCONSIN  
5. ZIP: 54901  
6. PHONE: (920) 426-1234  
7. DATE: 10/15/78  
8. TIME: 10:30 AM  
9. FROM: JANE WARDEN DOWDY  
10. TO: [illegible]  
11. SUBJECT: [illegible]

[Faint, mostly illegible text block, possibly a letter body or additional address information.]

12. SIGNATURE: [illegible]  
13. DATE: 10/15/78  
14. TIME: 10:30 AM  
15. FROM: JANE WARDEN DOWDY  
16. TO: [illegible]  
17. SUBJECT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The plate remains a carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 31032

FOR  
1 - STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>CLARICE P McKeever-MARTIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 13, 1987</b>		2b. HOUR <b>0830 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 25, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired - Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Millersville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>64 Rol-Park Trailer Village</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Humbert</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Letitia Wakefield</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-09-5778</b>		17. INFORMANT ADDRESS <b>Frances Hartlove, 544 Marc Rd., Millersville</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe chest lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CHF, mitral insufficiency, Scleroderma</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>[Signature]</b>		22c. DATE SIGNED <b>11/13/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASANT K KHANDLWAL, M.D.</b>		22e. ADDRESS <b>7422 BALTIMORE-ANNAPOLIS BLVD GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 16, 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard MD</b>					
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31033

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Marie Merkel			2a. DATE OF DEATH MONTH DAY YEAR Nov. 26 1987		2b. HOUR 11 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr. 5, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Severna Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1 Leeward Court 21146		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker
13a. STATE Maryland			13b. COUNTY A.A. Co.	13c. CITY OR TOWN Severna Pk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George F. O'Brecht			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma M. Schmidt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-52-4810	17. INFORMANT ADDRESS W. Calvin Gray, Jr. Same as #13		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-5-</u> 19 <u>83</u> to <u>11-26</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Hilary T. O'Herlihy</u>		DEGREE		22c. DATE SIGNED 11-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Hilary T. O'Herlihy, M.D.		22e. ADDRESS 325 Hospital Dr., Glen Burnie, Md.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/30/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., A.A. Co., Md.
24. FUNERAL DIRECTOR NAME McCully Funeral		24b. ADDRESS 237 E. Patapsco Ave., Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR DEC 01 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodette</u>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-2-1931

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BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove confidential information from page 1, mark 2, should be filed after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked as item 21 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

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REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31034

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gail Frances Miller			2a. DATE OF DEATH MONTH DAY YEAR November 5, 1987		2b. HOUR 10:27 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 15, 1935		
6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Cashier		12b. KIND OF BUSINESS OR INDUSTRY Marriott Corp.		13. STREET ADDRESS / ZIP CODE Apt. G. 301 Crain Highway S.E. 21061		
14. FATHER'S NAME FIRST MIDDLE LAST Leonard F. Kane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara E. Baxter		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
17. INFORMANT Daughter Christine Dalfonzo		18. SOCIAL SECURITY NO. 218.32.5862		19. ADDRESS 437 Westside Blvd Catonsville, Md. 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dark Renal Failure</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11-5-87</u> to <u>11-5-87</u> that (I) (we) last saw the deceased alive on <u>11-5-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Hilary O'Herlihy</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-6-87</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 7, 1987		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc./Catonsville		
23d. LOCATION CITY OR TOWN COUNTY STATE Balt. Md.		24. FUNERAL DIRECTOR NAME Singleton Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 10 1987		
25b. REGISTRAR'S SIGNATURE <u>Davidson-Pandora</u>		25c. ADDRESS Glen Burnie, Maryland				

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FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31035

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/22/87</b>			2b. HOUR M <b></b>	
3. SEX <b>MALE</b>		4. RACE <b></b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 20 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNARUNDAL Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>ANNARUNDAL</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ARUNDEL GERIATRIC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	
13a. USUAL RESIDENCE (IF MARSHING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN MILLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY JONES</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
17a. SOCIAL SECURITY NO. <b>218-36-8446</b>		17b. INFORMANT <b>MR HARRY WEBER</b>		17c. ADDRESS <b>SAME</b>		17d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 20 87</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Car accident - pedestrian struck</b>			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>STREET</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11/20 87 to 11/20 87</b>		22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>11/20 87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <b>E. G. Gaydos</b>		22c. DEGREE <b>MD</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>11/29/87</b>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. G. Gaydos</b>		22g. ADDRESS <b></b>					

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>		23b. DATE <b>11-25-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE Co MD</b>	
24. FUNERAL DIRECTOR NAME <b>RACOROWSKI</b>		24b. ADDRESS <b>FUNERAL HOME 5555 FLEET ST</b>		24c. DATE FILED BY REGISTRAR <b>NOV 27 1987</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove checkboxes. Pages 1 and 2 should be filed with in 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR STATE REGISTRAR *M.E.D. 11/24/87*

2- DECEASED NAME (TYPE OR PRINT) *Donald Alexander Minner*

3. SEX *male* 4. RACE *white* 5. DATE OF BIRTH *7 31 20* 6. AGE (IN YEARS) *67* 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS.

2a. DATE KNOWN OF DEATH *11-19-87* 2b. HOUR *2:20 P*

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) *Delaware* 7b. CITIZEN OF WHAT COUNTRY? *U.S.A* 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH *Anne Arundel County*

10. CITY OR TOWN OF DEATH *Annapolis* 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION *Anne Arundel General Hospital* 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) *Electrical Engineer* 12b. KIND OF BUSINESS OR INDUSTRY *Public Utilities*

13a. STATE *MD* 13b. CITY OR TOWN *ANNAPOIS* 13c. INSIDE CITY LIMITS? ☒ YES ☐ NO 13d. STREET ADDRESS *1735 LONG GREEN DR*

14. FATHER'S NAME *FRANK* 15. MOTHER'S MAIDEN NAME *ELIZABETH*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? *Yes* 16b. SOCIAL SECURITY NO. *222-09-9983* 17. INFORMANT *VIRGINIA C MINNER* ADDRESS *#13*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: *Multiple injuries*  
IMMEDIATE CAUSE (a) *8181*  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) *Due to, or as a consequence of*  
(c) *Due to, or as a consequence of*

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  
*Metastatic renal cell carcinoma*

19a. DATE OF OPERATION *11-23-87* 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? *Passenger in auto fell and run over* 20. AUTOPSY? ☒ YES ☐ NO

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH *9:23 PM 11-18-87* 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR *9:23 PM 11-18-87* 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) *Passenger in auto fell and run over*

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK *street* 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) *street* 21f. LOCATION *Rte. 750 near Prince Road, Anne Arundel Co, MD*

22a. I certify that I took charge of the remains described above, held an autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: *Natural causes* ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *John E. Smialek* TITLE (SPECIFY) *Chief* DATE SIGNED *11-21-87*

EXAMINER'S NAME (TYPE OR PRINT) *John E. Smialek, M.D.* ADDRESS *111 Penn Street, Baltimore, MD 21201*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) *Cremation* 23b. DATE *11-23-87* 23c. NAME OF CEMETERY OR CREMATORY *Westview Park* 23d. LOCATION CITY OR TOWN *Baltimore* COUNTY *MD* STATE *MD*

24. FUNERAL DIRECTOR NAME *T. A. Haeleky* ADDRESS *Ann. Md. 21401* 25a. DATE RECD. BY REGISTRAR *NOV 23 1987* 25b. REGISTRAR'S SIGNATURE *Julia Davidson-Randall*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8731037  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HEATHER Casey Erin MITCHELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 20, 1987</b>			2b. HOUR <b>12:01AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 12 1987</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>2 8</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Pasadena</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>84 Johnson Rd. Pasadena</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) =====		12b. KIND OF BUSINESS OR INDUSTRY =====		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Steven W. Mitchell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tammie L. Ritter</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) =====		17. INFORMANT ADDRESS <b>Steven W. Mitchell Same as 13c</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>central hypoventilation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>brain dysfunction</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>November 13, 1987</b> to <b>November 20, 1987</b> , that (I) (we) last saw the deceased alive on <b>November 16, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Alice Tanner, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-20-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alice Tanner, M.D.</b>					22e. ADDRESS <b>5515 Ritchie Highway, Baltimore MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11 21 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Howard Co. Md. 21225</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>George Gonce 4001 Ritchie Hwy Balto Md 21225</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

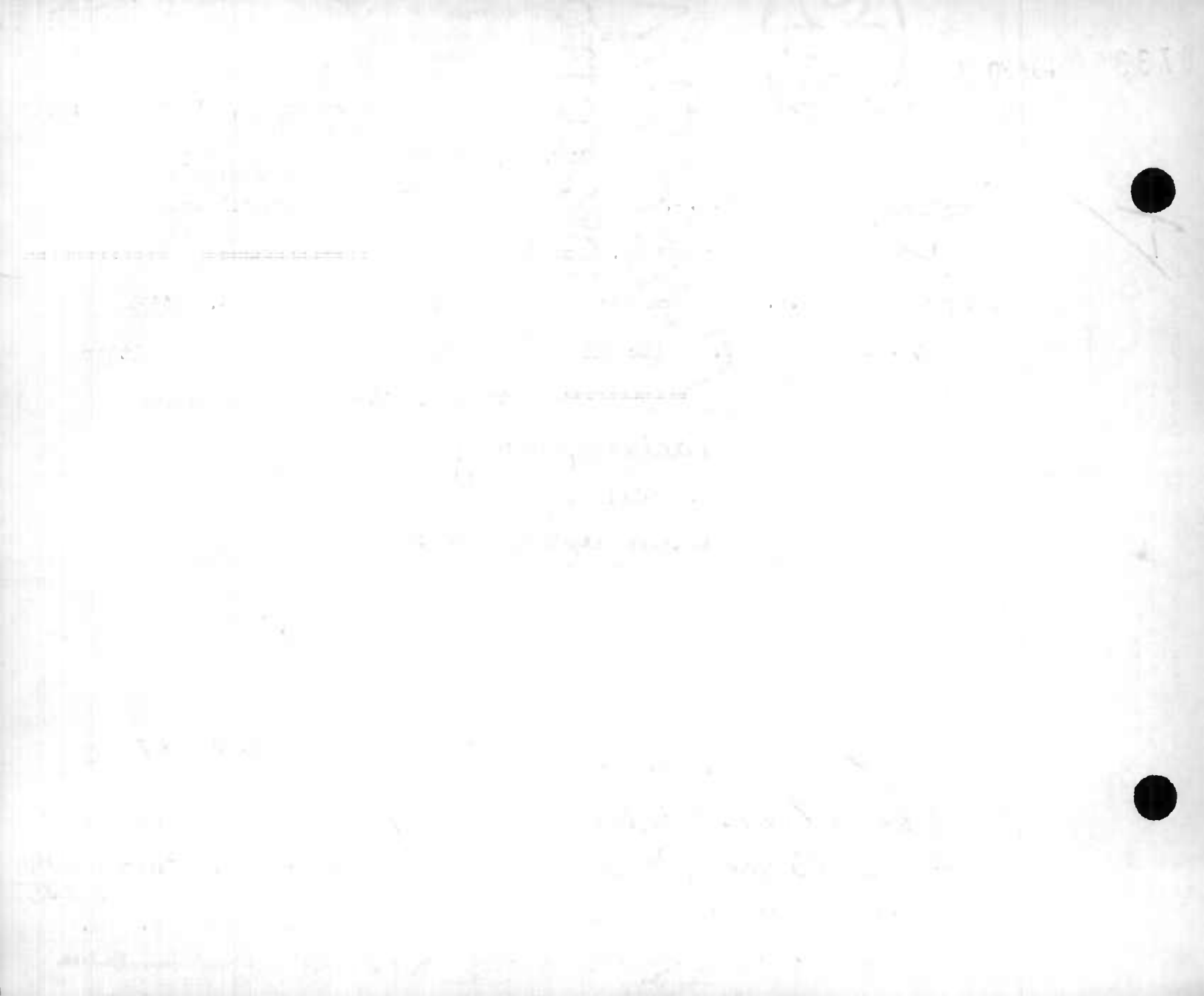
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's report must be filed.

BP \_\_\_\_\_



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 1 0 3 85

1. DECEASED NAME (TYPE OR PRINT) William Ellsworth		2a. DATE OF DEATH MONTH DAY YEAR 11/6/87		2b. HOUR 12 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 23 1892		6. AGE (IN YEARS LAST BIRTHDAY) 95	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mich.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Tracy's Landing	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 387 Deale Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY US Gov't
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY AA	13c. CITY OR TOWN Tracy's Ldg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Milton Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Wagner		20751 20904	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW I 223 30 1390		17. INFORMANT ADDRESS 2931 Shepperton Terr. Mr. C.P. Zilliagus Silver Spring, MD	
18. CAUSE OF DEATH (Enter only one cause for Part I. Do not enter more than one cause for Part I.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer, Prostate DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 5 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) Blind, deaf, abdominal aortic aneurysm.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) No injury	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 76 11/6 87	
22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 11/6 87, that (I) (we) last saw the deceased alive on 11/6/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles H. Wirth		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. TIME SIGNED 11/6/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Wirth		22f. ADDRESS Lothian, Md 20711			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 11-7-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD					
24. FUNERAL DIRECTOR NAME RAUSCH FH Owings, MD 20736		25a. DATE REC'D. BY REGISTRAR NOV 12 1987		25b. REGISTRAR'S SIGNATURE Julia Southern-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete the back papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



WMS 1/16/17

1/16/17

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 31039  
REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (LAST, FIRST, MIDDLE) <b>Nicholas Adam Nonnenmacher</b>		2b. DATE OF DEATH MONTH DAY YEAR <b>November 4 1987</b>		2c. HOUR <b>9:50 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEP 14 1990</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>97</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD</b>	
10. CITY OR TOWN OF DEATH <b>Arnold</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>491 Broadwater Rd</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Steel</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN <b>MARYland Anne Arundel Arnold</b>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE <b>491-Broadwater Rd 21012</b>			
14. FATHER'S NAME FIRST MIDDLE <b>John Adam Nonnenmacher</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Susanna Huth Huth</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) <b>World War I 097050678</b>	
17. INFORMANT ADDRESS <b>Nicholas T Nonnenmacher (son) 491 Broadwater Arnold Md 21012</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>12 years</b> <b>12 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 20 1987</b> to <b>Nov 4 1987</b> , that (I) (we) saw the deceased alive on <b>Aug 13 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>T. C. Cullis MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4 Nov 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T. C. CULLIS M.D.</b>		22e. ADDRESS <b>7-Riggs Ave Severna Park Md 21146</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11-9-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St John's Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Queens, N.Y.</b>	
24. FUNERAL DIRECTOR <b>Robert J. Bananco</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
<div>FOR</div> <div>1- STATE REGISTRAR</div>											
<div>2a DECEASED NAME</div> <div>(TYPE OR PRINT)</div> <div>FIRST MIDDLE LAST</div> <div>EUGENE LEROY O'NEALE</div>					<div>2b DATE OF DEATH</div> <div>MONTH DAY YEAR</div> <div>NOV. 9, 1987</div> <div>2b HOUR</div> <div>2:27 PM</div>						
<div>3 SEX</div> <div>MALE</div>		<div>4 RACE</div> <div>WHITE</div>		<div>5 DATE OF BIRTH</div> <div>MONTH DAY YEAR</div> <div>1 15 23</div>		<div>6 AGE</div> <div>(IN YEARS LAST BIRTHDAY)</div> <div>64 YRS</div>		<div>7a BIRTHPLACE</div> <div>(STATE OR FOREIGN COUNTRY)</div> <div>MARYLAND</div>			
<div>7b CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>		<div>8 MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED</div> <div><input type="checkbox"/> WIDOWED</div> <div><input type="checkbox"/> DIVORCED</div>		<div>9 BALTIMORE CITY OR COUNTY OF DEATH</div> <div>Anne Arundel MD.</div>							
<div>10 CITY OR TOWN OF DEATH</div> <div>Annapolis</div>		<div>11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION</div> <div>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</div> <div>Anne Arundel General Hospital</div>				<div>12a USUAL OCCUPATION</div> <div>(TYPE OF WORK FOR MOST OF WORKING LIFE)</div> <div>Carpenter</div>		<div>12b KIND OF BUSINESS OR INDUSTRY</div> <div>Construction</div>			
<div>13a USUAL RESIDENCE</div> <div>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)</div> <div>13a STATE</div> <div>Maryland</div>					<div>13b COUNTY</div> <div>A. Arundel</div>		<div>13c CITY OR TOWN</div> <div>Riva</div>		<div>13d INSIDE CITY LIMITS?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		
<div>14 FATHER'S NAME</div> <div>FIRST MIDDLE LAST</div> <div>EUGENE LEROY O'NEALE</div>					<div>15 MOTHER'S MAIDEN NAME</div> <div>FIRST MIDDLE LAST</div> <div>THELMA TAYLOR</div>						
<div>16a WAS DECEASED EVER IN U.S. ARMED FORCES?</div> <div>(YES, NO OR UNKNOWN)</div> <div>Yes</div>		<div>16b SOCIAL SECURITY NO.</div> <div>(IF YES, GIVE WAR OR DATES)</div> <div>1944-46</div>		<div>17 INFORMANT ADDRESS</div> <div>Marion Rogers O'Neale same as #13</div>							
<div>18 CAUSE OF DEATH</div> <div>(Enter only one cause per line for 1a), 1b), and 1c)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Cerebral anoxia.</u></div> <div> <div> <div> <div>DOES TO, OR AS A CONSEQUENCE OF</div> <div>(b) <u>Cardiac failure.</u></div> <div>DOES TO, OR AS A CONSEQUENCE OF</div> <div>(c) <u>Myocardial Infarction.</u></div> </div> <div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</div> </div> </div> </div>										<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div><u>immed.</u></div>	
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)</div> <div><u>Hypertension.</u></div>											
<div>19a DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>				<div>20a AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>		<div>20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>			
<div>21a. ACCIDENT WAS UNDERLYING</div> <div>OR CONTRIBUTING</div> <div>CAUSE OF DEATH</div> <div>(IF EITHER, NOTIFY MEDICAL EXAMINER)</div>		<div>21b TIME OF INJURY</div> <div>HOUR A.M. MONTH DAY YEAR</div> <div>P.M. 19</div>		<div>21c. HOW INJURY OCCURRED</div> <div>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)</div>							
<div>21d INJURY OCCURRED</div> <div>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/></div> <div>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/></div>		<div>21e PLACE OF INJURY</div> <div>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</div>		<div>21f. LOCATION</div> <div>STREET CITY OR TOWN COUNTY STATE</div>							
<div>22a. I certify that (I) (this hospital) attended the deceased from <u>7 Nov 87</u> to <u>9 Nov 87</u> that (we) lost saw the deceased alive on <u>9 Nov 87</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div>											
<div>22b SIGNATURE</div> <div><u>C. H. Chest</u></div>					<div>DEGREE</div> <div>MD.</div>			<div>22c DATE SIGNED</div> <div><u>10 NOV 87.</u></div>			
<div>22d. PHYSICIAN'S NAME</div> <div>(TYPE OR PRINT)</div>					<div>22e ADDRESS</div>						
<div>23a BURIAL, CREMATION, REMOVAL</div> <div>(SPECIFY)</div> <div>Burial</div>		<div>23b. DATE</div> <div>11/12/87</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Lakemont Memorial</div>		<div>23d. LOCATION</div> <div>CITY OR TOWN COUNTY STATE</div> <div>Davidsonville A.A. Md.</div>					
<div>24 FUNERAL DIRECTOR</div> <div>NAME ADDRESS</div> <div>Hardesty Funeral Home, Annapolis, Md.</div>					<div>25a DATE RECORDED BY REGISTRAR</div> <div>25b REGISTRAR'S SIGNATURE</div> <div>NOV 13 1987 <u>[Signature]</u></div>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOV 13 1957

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FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 37			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dolores C. Paff				2a. DATE OF DEATH MONTH DAY YEAR November 29, 1987				2b. HOUR P M 11:07 P			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 26 1922		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21146 58 W. Earliegh Heights Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Stewart Earhart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorretta Corwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-14-7515		17. INFORMANT ADDRESS David G. Paff (Same as 13 a-e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CIRRHOSIS OF THE LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEPATOMEGALY</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MAR 1986</b> <b>SEPT 1983</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a. DATE OF OPERATION <b>NONE</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>APRIL 3</b> , 19 <b>56</b> , to <b>NOV 29</b> , 19 <b>87</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>NOV 11</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Francis I. Codd</i>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12-1-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANCIS I. CODD</b>				22e. ADDRESS <b>674 RITCHIE HY, SEVERNA PARK, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Dec. 2, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN STATE <b>Baltimore 21146 Anne Arundel MD</b>			
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>				25b. SIGNATURE <i>John B. ...</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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071353 NOV 10 87

Item 14 film G634 12-2-87  
 FOR STATE per funeral home  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1042

1. DECEASED NAME (TYPE OR PRINT) Brenda Gail Paris-Lindsey		2a. DATE KNOWN OF DEATH ESTIMATED 11-4 19 87		2b. HOUR 8:10 p.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 17 55	6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7c. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Richard COY Paris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ferbie King		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 563-06-6727		17. INFORMANT ADDRESS Ferbie Paris 7405 South Road 21237
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chest Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 3:00 P.M. 11-4 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto which ran off road
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE off Rt. 198, Maryland City, Anne Arundel Co., Maryland
22a. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles P. Kokes		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 11-5-87
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-09-87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, A.A.Co., Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 6224 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR NOV 09 1987
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31043

073411 NOV 30 1987

1. DECEASED NAME (PRINT) Amanda M. Parkinson			2a. DATE OF DEATH MONTH DAY YEAR 11-25-87		2b. HOUR 5:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1899	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD.			13b. CITY OR TOWN A.A.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS - ZIP CODE 109 Tolson St. 21401
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Freeman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Rebecca Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-52-8169		
17. INFORMANT Raymond E. Parkinson			ADDRESS 536 Ritz Dr. Odenton, MD 21113		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic breast cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/10, 1987, to 11/24, 1987, that (I/we) lost saw the deceased alive on 11/24, 1987, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did not) view the body after death.					
22b. SIGNATURE R. I. Hochman, M.D.		DEGREE M.D.		22c. DATE SIGNED 11/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, M.D.		22e. ADDRESS 16 Microva Ave Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial	23b. DATE 11/28/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD.	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		ADDRESS Annapolis, MD.		25a. DATE REC'D. BY REGISTRAR NOV 27 1987	25b. REGISTRAR'S SIGNATURE J. S. Sinden-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #3. Page 4 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "other" above any injury, or other traumatic event, the medical examiner must be notified at once.

073-11-1870

James M. Smith  
Nov 21 1870  
Dear Sir  
I have the honor to acknowledge the receipt of your letter of the 19th inst. in relation to the matter of the  
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. M. Smith

James M. Smith  
Nov 21 1870  
Dear Sir  
I have the honor to acknowledge the receipt of your letter of the 19th inst. in relation to the matter of the  
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. M. Smith

James M. Smith  
Nov 21 1870  
Dear Sir  
I have the honor to acknowledge the receipt of your letter of the 19th inst. in relation to the matter of the  
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. M. Smith

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31044 EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM F PATTEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 12, 1987</b>		2b. HOUR <b>1.00 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 14, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Production Super.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insulators</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Arnold</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>778 Matchpoint Dr. / 21012</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-07-7422</b>		17. INFORMANT ADDRESS <b>Mrs. Dolores R. Patten (same as 13)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF TONGUE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>HYPOTHYROIDISM - HYPERCALCEMIA - HYPERTENSION</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/30/87</b> 19 to <b>11/12/87</b> 19, that (I) (we) lost saw the deceased alive on <b>11/11/87</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.					
22b. SIGNATURE <b>R. DAVID ROSE, M.D.</b>		DEGREE		22c. DATE SIGNED <b>11/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>200 HOSPITAL DRIVE, SUITE 500 GLEN BURNIE, MARYLAND. 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-14-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Brooklyn</b>		COUNTY <b>A.A.</b>		STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>JOHN SEVERNA PARK, MD. 21146</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low number that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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NOVEMBER 12, 1957 1:00 PM

WASH. STATE COUNTY

WORTH WINGED HOSPITAL

GEN. DUNN

100 HOSPITAL DRIVE, SUITE 300  
GEN. DUNN, WASH. STATE

R. DAVIS ROSE, M.D.

073852 DEC 13

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1045

1. DECEASED NAME (TYPE OR PRINT) <b>Judith A. Peebles</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>11/19/87</b>			2b. HOUR <b>1200</b>		
3. SEX <b>F</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>1</b> YEAR <b>39</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>48</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>19</b> YEAR <b>87</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b>		
10. CITY OR TOWN OF DEATH <b>Severna Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Foster Home</b>
13a. STATE <b>MD</b>			13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Severna Park</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>292 Tolstoy Ln.</b>		
14. FATHER'S NAME FIRST <b>Ira</b> MIDDLE <b>Ralph</b> LAST <b>Atticks</b>				15. MOTHER'S MAIDEN NAME FIRST <b>June</b> MIDDLE <b>Harm</b> LAST <b>Harm</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-36-5017</b>		17. INFORMANT <b>Ross G. Peebles</b> ADDRESS <b>13450 Mahan # 337 Dallas, Texas 75248</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS CVD.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <b>William P. Jones</b>		TITLE (SPECIFY) <b>M.D. Deputy</b>				MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>		ADDRESS <b>2444 Solomons Is. Rd Annapolis, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 21, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>			23d. LOCATION CITY OR TOWN <b>Alexandria, Fairfax, Virginia</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b> ADDRESS <b>16000 Annapolis Rd Bowie, Maryland 20715</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rudolph</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1 AND 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

013-82-00-317

11 12 13 14

15 16 17 18 19 20

AA

Government House

11 12 13 14 15 16 17 18 19 20

11

General Agent

ASAND

Director of

11 12 13 14 15 16 17 18 19 20

11 12 13 14 15 16 17 18 19 20

William R. Jones Deputy

11 12 13 14 15 16 17 18 19 20

013-82-00-317

071675 NOV 13 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 1 0 4 6

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Jeffrey

Garrett

Peeler

2a. DATE KNOWN OF DEATH  
ESTIMATED ☒ MONTH DAY YEAR  
11-8 19 87

7b. HOUR  
M

1. SEX  
Male

4. RACE  
White

5. DATE OF BIRTH  
MONTH DAY YEAR  
Dec. 31, 1957

6. AGE (IN YEARS)  
(LAST BIRTHDAY)  
29 YRS.

IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.  
HOURS MIN.

2c. DATE PRONOUNCED DEAD  
MONTH DAY YEAR  
11-9 19 87

2d. HOUR  
p. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Md.

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel County, MD.

10. CITY OR TOWN OF DEATH

Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

7889 L Tall Pines Court

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Hair Dresser

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Luxton

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS

26 Judges Lane 21204

14. FATHER'S NAME

Joseph

G.

Peeler Jr.

15. MOTHER'S MAIDEN NAME

Nancy

T.

Mather

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

218-76-6821

17. INFORMANT

ADDRESS

Joseph G. Peeler Jr Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Narcotic Intoxication

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 11-8 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

subject used drug

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
Home

21f. LOCATION

7889 L Talls Pines Ct., Glen Burnie, Anne Arundel Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒.

ACTUAL SIGNATURE

TITLE (SPECIFY)  
Deputy Chief  
M.D. MEDICAL EXAMINER

DATE SIGNED 11-10-87

EXAMINER'S NAME  
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Nov. 13, 1987

23c. NAME OF CEMETERY OR CREMATORY

Moreland Memorial

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

Maryland

STATE

24. FUNERAL DIRECTOR

NAME ADDRESS  
Leonard J. Ruck Inc. Baltimore, Maryland

25a. DATE REC'D. BY REGISTRAR

NOV 12 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



710 25-10-1964

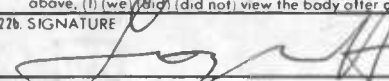
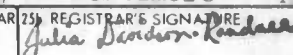


072268 NOV 18 1987

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31047 EST

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY E PIEDRAFITE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 12, 1987</b>		2b. HOUR <b>1:18 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 11, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward E. Eyring</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Matthew</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219 05 1794</b>	17. INFORMANT ADDRESS <b>Marybeth Piedrafite (Same as 13a-e)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Metastatic Breast Cancer</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours</b> <b>3 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Brain Metastasis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-9</b> 19 <b>87</b> , to <b>11-12</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-12</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-12-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LONG S. HSU, M.D.</b>		22e. ADDRESS <b>300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND. 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 14, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lulaney Valley Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>		ADDRESS <b>3204 Mountain Rd Pasadena, MD 21123</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>	25b. REGISTRAR'S SIGNATURE 

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

012200 NOV 1967

ASSISTANT

PHYSICIAN

NOVEMBER 12, 1967

WASH STATE COUNTY

NORTH WASHINGTON HOSPITAL

GRAND JURY

200 Hospital Drive, Suite 150  
Spokane, Washington 99201

LONG 2-4211

NOV 17 1967

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31048

1 - FOR  
STATE  
REGISTRAR

DECEASED NAME (LAST, FIRST, MIDDLE OR PRINT) <b>Doris Preston Pletcher</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 1, 1987</b>		2b. HOUR P. M. <b>P. M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 3, 1906</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Edgewater</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Spencer Carpenter Brearley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Banks</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>091-05-3226</b>		17. INFORMANT ADDRESS <b>807 Robertson Avenue Copperas Cove, TX 76522</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE &amp; SHUTDOWN</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MALNUTRITION DEHYDRATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE PHLEBITIS ERYSIPELAS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b> <b>1 year</b> <b>5 DAYS</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Coughs, Heart Failure - Emphysema - Atrial Fibrillation</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> , 19____, to <b>present</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/1/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Peter F. Verkouw</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-2-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER F. VERKOUW</b>		22e. ADDRESS <b>1833 FOREST DR. Annapolis, Md 21401</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 3, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Switland PG. MD</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Robertson-Randall</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-101-200

100-101-200

100-101-200

100-101-200

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100-101-200

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

073434 DEC - 87

REG. NO. 87 31049

1. DECEASED NAME (TYPE OR PRINT) <b>NELLIE</b>		FIRST <b>BLANCHE</b>		MIDDLE <b>PROCTOR</b>		LAST		2a. DATE OF DEATH MONTH <b>November</b> DAY <b>24</b> YEAR <b>1987</b>		2b. HOUR		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>17</b> YEAR <b>1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE COUNTRY <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD						
10. CITY OR TOWN OF DEATH <b>Harwood</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brashear's Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Household</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>				13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Shady Side</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4806 Woods Wharf Rd 20764</b>		
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Augustus</b> LAST <b>Crandell</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mattie</b> MIDDLE <b>Evans</b> LAST <b>Evans</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-74-3334</b>		17. INFORMANT ADDRESS <b>Iva Ford # 13e</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Resp Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>COMPLETE HEART BLOCK</b>										6 Mo.		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>76</b> , to <b>Nov</b> , 19 <b>87</b> , that (I) <del>have</del> lost saw the deceased alive on <b>10-19-87</b> , 19 <b></b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <b>did not</b> view the body after death.												
22b. SIGNATURE <b>Harvey J Steinberg MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/24/87</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARVEY J STEINBERG</b>		22e. ADDRESS <b>SHADYSIDE MD 20764</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-27-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. James Episcopal</b>		23d. LOCATION CITY OR TOWN <b>Lothian</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>						
24. FUNERAL DIRECTOR <b>T.A. Hardesty</b>		ANNAPOLIS MD. 21401		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

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Item 15 Film G633 11-30-87 sh  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 0 5 0

1. DECEASED NAME (TYPE OR PRINT) <b>Veronica L. Raineri</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 16 19 87</b>			2b. HOUR M <b>6:16a</b>		
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>6-20-67</b>	6 AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>20</b>	IF UNDER 1 YR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 16 19 87</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD		
10 CITY OR TOWN OF DEATH <b>Gambrills</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>950 Autumnwood Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY -----
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Md</b>	13b. COUNTY <b>A.A. Co.</b>	13c. CITY OR TOWN <b>Gambrills</b>	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>950 Autumnwood Dr 21054</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph S. Raineri</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Linda L. Coon</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-06-1711</b>		17. INFORMANT ADDRESS <b>Joseph S. Raineri 950 Autumnwood</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>9104</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Seizure disorder</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>11 16 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Recovered under water in bathtub</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>950 Autumnwood Drive, Gambrills, A.A. Co, MD.</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER					DATE SIGNED <b>11/16/87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>		ADDRESS <b>111 Penn St. Balto.MD.,</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-19-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville A.A. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>T.A. Hardesty Annapolis Md 21401</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Gabe Davidson-Randall</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM F-107. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31051ST

1. DECEASED NAME (1st OR PRINT) <b>CHARLES S RAINES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 25, 1987</b>		2b. HOUR <b>517 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>October 7, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arunde</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>516 Stanhome Drive 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Seldon Raines</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Werner</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-28-6728</b>		17. INFORMANT ADDRESS <b>Josephine Raines, same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Metastatic Colon Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-24</b> , 19 <b>87</b> , to <b>11-25</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-25</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-25-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LONG S. HSU, M.D.</b>		22e. ADDRESS <b>300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>28 Nov. 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A., MD</b>		24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, 421 Crain Hwy, S.E. Glen Burnie, MD 21061</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 31052  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Herbert Frederick Rau, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 13, 1987</b>		2b. HOUR <b>8:45A</b> M					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 31, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.				
10. CITY OR TOWN OF DEATH <b>Severn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>946 Smith Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Exxon Chemical</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>946 Smith Road 21144</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Rau</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna May Sauter</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>NA</b>		17. INFORMANT (Wife) <b>Dora B. Rau</b>		ADDRESS <b>Same as #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Small cell Lung Cancer metastatic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>To Liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Obstructive Pulmonary Disease</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>82</b> , to <b>November 13</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Mayer Gorbaty</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/14/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Moyer Gorbaty, M.D.</b>				22e. ADDRESS <b>95 Aquahart Road Glen Burnie, Maryland 21061</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 16, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ft. Meade Anne Arundel Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>				ADDRESS <b>Glen Burnie, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick R. R...</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

WELLS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST FRANK		MIDDLE J		LAST REESE	
2a. DATE OF DEATH		MONTH Nov.		DAY 25		YEAR 1987		2b. HOUR A M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1489 Amberwood Dr., So.		12a. USUAL OCCUPATION (WORKING LIFE) Maintenance Engineer		12b. KIND OF BUSINESS OR INDUSTRY 2100			
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1702 Oakhill Place	
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Reese, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Troll		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE DATES) Yes 1954-1958		16b. SOCIAL SECURITY NO. 220-32-0386		17. INFORMANT Steve M. Reese	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease + Bypass</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular Arrhythmia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) lost saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald H. Hislop		22c. DATE SIGNED 11-25-87		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Donald H. Hislop		23b. ADDRESS Robinson Rd. + Owens Way, Severna Park, MD							
23c. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23d. DATE 11/28/87		23e. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery		23f. LOCATION CITY OR TOWN COUNTY Davidsonville A.A. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel, Annapolis, MD		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. L. Friedman		NOV 27 1987			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31054

1. DECEASED NAME (TYPE OR PRINT) <b>DOUGLAS F. KESSLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 30 87</b>		2b. HOUR <b>8:45 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 17 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co</b> MD.
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>RAYMOND JAY RESSLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCES FOLSAM FREY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>207-10-6763</b>		17. INFORMANT ADDRESS <b>186 W. LAKE DR. ANNAPOLIS, MD 21403</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic lung Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Large cell Ca).</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1971</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Present</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29/87</b> , 19____, to <b>11/30/87</b> , 19____, that (I) (we) saw the deceased alive on <b>11/29/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Peter F. Verkouuw MD</b>		DEGREE <b>MD</b>			22c. DATE SIGNED <b>11-30-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER F. VERKOUW</b>		22e. ADDRESS <b>1833 FOREST DRIVE ANNAPOLIS, MD 21401</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>State Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

013002 DEC-30



2100306547



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove or destroy pages 1 and 2 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 3105 EST  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHESTER RANDOLPH RINKER JR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 29, 1987</b>		2b. HOUR <b>803 AM</b>						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 29 1918</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (Net) <b>V.P. Prod. Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Canvas Business</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>211 Hollywood Ct. 21061</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chester R. Rinker, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Loos</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT (Wife) <b>Elizabeth Rinker</b>			ADDRESS <b>Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>8/8/87</b> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Alejandro Montoya M.D.</b>						DEGREE		22c. DATE SIGNED <b>10.29.87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS <b>7845 OAKWOOD ROAD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Oct 30, 1987</b>			23c. NAME OF CEMETERY OR CREMATOR <b>Security Process, Inc. Catonsville A.A. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 03 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Barber-Randall</b>			

MEDICAL CERTIFICATION

FROM: WABTEL CHAIR

RE: NORTH VIRGINIA EXPLORATION

DATE: 03/17/88

TO: WABTEL CHAIR

FROM: WABTEL CHAIR

RE: NORTH VIRGINIA EXPLORATION

073365 NOV 30 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) <b>Shirley Leone Robinette</b>					2. DATE OF DEATH MONTH DAY YEAR 7b HOUR <b>November 24, 1987</b> M					
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 13, 1918</b> AR		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>727 Delmar Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary (Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Md. D.M.V.</b>		
13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Anne Arundel</b>		13c. STREET ADDRESS / ZIP CODE <b>727 Delmar Ave. 21061</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harrison Eckerson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/a</b>		17. INFORMANT (Son) <b>Mr. Jon D. Robinette</b>		ADDRESS <b>268 Rebecca Ann Ct. Millersville, Md. 21108</b>				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cor Pulmonale</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>14 Wellham Ave., Glen Burnie, Md. 21061</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>8-2-</b> 19 <b>86</b> to <b>11-24-</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-27-</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Chackumkal V. Cyriac</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-24-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Chackumkal V. Cyriac</b>				22e. ADDRESS <b>14 Wellham Ave., Glen Burnie, Md. 21061</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 28, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process Inc.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>R. A. Hyckman</b>				ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md. 21061</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

BP

NOV 17 1950

POST OFFICE



Handwritten text, possibly a letter or address, mostly illegible due to fading.

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072546 NOV 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHREG. NO. 31057  
EST

1. DECEASED NAME (TYPE OR PRINT) <b>MARTIN HENRY ROGERS JR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 18, 1987</b>			2b. HOUR <b>912 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 4 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Trucker</b>		12b. KIND OF BUSINESS OR <b>Mountainside Transport</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>301 Maryland Ave. 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin H. Rogers, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Teresa Welch</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT (Wife) <b>Mrs. Celestina A. Rogers</b>		ADDRESS <b>Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous due to Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus, Arteriosclerotic Heart disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Nov 18 87</b>					
22a. I certify that (I) (the hospital) attended the deceased from <b>10-17</b> 19 <b>87</b> , to <b>Nov 18</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-17</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE <b>Joseph Taler, M.D.</b>				DEGREE <b>Ph.D.</b>				22c. DATE SIGNED <b>11-18-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Taler, M.D.</b>				22e. ADDRESS <b>95 AQUHART ROAD</b>					
23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION (SPECIFY) <b>Burial</b>		23b. DATE <b>November 20, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLEN BURNIE, MARYLAND</b>		23d. CITY OR TOWN <b>21061</b>		23e. COUNTY <b>ANNE ARUNDEL</b>	
24. FUNERAL DIRECTOR NAME <b>R. A. Perkins</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Tindler-Randall</b>			
24. FUNERAL HOME <b>Singleton Funeral Home, Glen Burnie, Md. 21061</b>									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and file it within 72 hours after death.

IMPORTANT: If item 21 is marked off, item 18 should show any injury, or other traumatic event, the medical examiner should be notified of office.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87 REG. NO 31058		71917 NOV 16					
2a DECEASED NAME (TYPE OR PRINT) Jacqueline Anne Ryan				2b DATE OF DEATH MONTH DAY YEAR November 8, 1987		2c HOUR 1249 PM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH June 24 1932		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS 7b IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10 CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Media Aid (Ret)		12b KIND OF BUSINESS OR INDUSTRY A A Co.	
13a STATE Maryland				13b COUNTY Anne Arundel		13c CITY OR TOWN Glen Burnie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward H. Kingsley				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Maher					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17 INFORMANT (Husband) Gary J. Ryan		ADDRESS Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 6/3 83 11/8 87					
22a I certify that (I) (this hospital) attended the deceased from <u>11/6</u> 19 <u>87</u> , to <u>11/8</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/6</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.									
22b SIGNATURE <u>E W Cole III</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 11/9/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III				22e ADDRESS 51 FRANKLIN ST ANNAP MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov 14, 1987		23c NAME OF CEMETERY OR CREMATORY Millport Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Millport Chemung New York			
24 FUNERAL DIRECTOR NAME <u>Singleton</u> ADDRESS Singleton Funeral Home Glen Burnie, Maryland				25a DATE REC'D. BY REGISTRAR NOV 13 1987		25b REGISTRAR'S SIGNATURE <u>Julia Dearden-Randall</u>			

NOV 19 1963

4



NOV 13 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers; Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07299-1-25 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31059 EST

1. DECEASED NAME (TYPE OR PRINT) RICHARD CARROLL SAMPSON SR			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 23 1987			2b. HOUR 636 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 15 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (Ret) Locomotive Engineer		12b. KIND OF BUSINESS OR INDUSTRY Com Rail		
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 523 Munroe Circle 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Edmund Sampson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Stranz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Wife) Mrs. Lillian M. Sampson		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> , 19 <u>87</u> , to <u>11-23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-23-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.			22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME R. H. Fisher			ADDRESS Singleton Funeral Home, Glen Burnie, Maryland			25a. DATE REC'D. BY REGISTRAR NOV 24 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

073 2 2 350

WORTH AVENUE HOSPITAL

CITY OF BOSTON

to the Board of Health  
of the City of Boston

RECEIVED

THE BOARD OF HEALTH

1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 31060			
1. DECEASED NAME (TYPE OR PRINT) <b>ESTELLE A. SARTAIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-11-87</b>			
3. SEX <b>FEMALE</b>				2b. HOUR <b>4:30 PM</b>			
4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 3, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL Cty., MD.</b>			
10. CITY OR TOWN OF DEATH <b>EDGEWATER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PLEASANT LIVING CON. CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>THEATER</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>P.G. CO.</b>		13c. CITY OR TOWN <b>COLMAR MANOR</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William - SALZMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BELLE - HARVEY</b>		13e. STREET ADDRESS / ZIP CODE <b>4302 MONROE ST. / 20722</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-284668</b>		17. INFORMANT ADDRESS <b>PEGGY HYSAN 350 RIVERSIDE RD. EDGEWATER, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bladder CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>Dr. Charles W. Kinzer</u> attended the deceased from <u>5/11</u> , 19 <u>86</u> , to <u>Nov. 11</u> , 19 <u>87</u> , that <u>he</u> (was) (was not) saw the deceased alive on <u>Nov. 10</u> , 19 <u>87</u> , and that in <u>my</u> (own) (another's) opinion death occurred on the date and hour and from the causes stated above. (If <u>we</u> (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kinzer</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>NOV. 12, 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. CHARLES W. KINZER, MD.</b>		22e. ADDRESS <b>16 MURRAY AVE. ANNAPOLIS, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-17-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARLINGTON C. VIRGINIA</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>CHAMBERS FUNERAL HOME RIVERDALE, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

BP \_\_\_\_\_

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072228 NOV 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. THAT IT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31061		
1. FOR STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST Kenneth M. Schaeffer										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 11-12 1987		2b. HOUR M 11:30 P.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 7, 1987		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS YRS. 5	IF UNDER 1 YR. DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-12 1987		2d. HOUR M 11:30 P.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland		13b. COUNTY AA	13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7905 Solley Road		21061				
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth Schaeffer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Nicklas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Barbara N. Schaeffer, Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER			DATE SIGNED 11-13-87			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 14, 87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD				
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR NOV 17 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Swinton-Rudner</i>			

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100% COTTON LITRE

CHARLES W. WOOD



NOV 11 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) <b>MARY Elizabeth Shearer</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-29-87</b>		2b. HOUR <b>0939</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 10, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Architect of The Capitol</b>		
13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Davidsonville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William B. Blakemore</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate May Bolen</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>579-58-5232</b>		17. INFORMANT (Son) <b>908 Mt. Airy Road</b> <b>Carleton E. Shearer Davidsonville, Md. 21035</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETES</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1985</b> to <b>Nov 87</b> , that (I) (we) lost saw the deceased alive on <b>Nov 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John D. Jackson MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-29-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN D. JACKSON MD</b>						22e. ADDRESS <b>1833 FOREST DR. ANNAPOLIS, MD 21401</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/02/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>						25. REGISTRATION <b>DEC-4-1987</b>				
26. ADDRESS <b>4739 Baltimore Avenue Hyattsville, Md. 20781</b>						27. REGISTRAR'S SIGNATURE <b>John D. Jackson</b>				

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DEC-4-1964



073119 NOV 25 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 31063  
REG. NO. EST

1. DECEASED NAME (TYPE OR PRINT) <b>AGNES JOSEPHINE SHIROKY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 15, 1987</b>			2b. HOUR <b>0750 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 23, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92 YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Czechoslovakia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>mother</b>
13a. STATE <b>Md.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>_____</b>			13e. STREET ADDRESS <b>135 Truckhouse Rd./21146</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-2823</b>		17. INFORMANT ADDRESS <b>Mr. Joseph F. Shiroky (same as 13)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>congestive heart failure, mild insufficiency</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>May 1983</b> to <b>11-15 1987</b> , that (I) (we) lost saw the deceased alive on <b>11-15 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Basant K. Khandelwal</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/15/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASANT K. KHANDELWAL, M.D.</b>				22e. ADDRESS <b>7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-17-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. MD</b>		
24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCO</b>				ADDRESS <b>SEVERNA PARK, MD. 21146</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		26. REGISTRAR'S SIGNATURE <b>Julia Tindon-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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NOVEMBER 19, 1964 0730 AM

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ANDERSON COUNTY

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WHITE-ANDERSON

WHITE-ANDERSON HOSPITAL  
WHITE-ANDERSON HOSPITAL

WHITE-ANDERSON HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		87 31064				REG. NO.					
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
KENNETH		W.		SMITH		SR.		11 / 20 / 87		0455 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		B V		MONTH DAY YEAR 10 / 03 / 22		65 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				A.A.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
ANNAPOLIS		AA Gen Hosp									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		A.A.		LOTHIAN		YES <input type="checkbox"/> NO <input type="checkbox"/>		5037 Solomons Island Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
ALBERT		SMITH		CLARLETTE SELLMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT							
YES		W.W.II		Lothian, MD 20711 ADELL M. SMITH 5037 Solomons Island Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp. arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER (metastatic)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>86</u> to <u>11 / 20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11 / 19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
<u>W. A. Dabbs</u>				11 / 20 / 87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
DABBS, W. A.		703 Giddens Ave, Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		11-25-1987		MT. ZION CEMETERY		Lothian		A.A. Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
WILLIAM REESE & SONS MORTUARY, P.A.		NOV 25 1987		<u>Julia Davidson-Randall</u>							

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31065

1. DECEASED NAME (TYPE OR PRINT) <b>Willie D. Spicer</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/18/87</b>		2b. HOUR <b>8:40 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 23 20</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.			
10. CITY OR TOWN OF DEATH <b>Millersville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Knollwood Manor</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coal miner</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		13a. STREET ADDRESS / ZIP CODE <b>Rt. 1 24736 99999</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Spicer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann Robinson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 235-18-8042</b>		17. INFORMANT <b>Pasadena, MD 21122</b> <b>Patricia Smith, 204 Oak Hollow Court</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Alcoholic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dementia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Small Bowel obstruction - Perforation (Peritonitis)</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>I have not seen the patient</b> that (I) (we) last saw the deceased alive on <b>11-19-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Oscar A. Farias</b>		DEGREE <b>Medical doctor</b>		22c. DATE SIGNED <b>11-19-87</b>	
22d. ADDRESS <b>Dr. Farias is covering for Dr. Rhodes</b>		22e. ADDRESS <b>both doctors are located at this</b> <b>Oscar A. Farias/Paul S. Rhodes, M.D. 1667 Crofton Ctr, Crofton, MD 21114</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 21, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Mem. Park</b>	
23d. LOCATION <b>Bluemont</b>		23e. COUNTY <b>Mercer</b>		23f. STATE <b>W. Va.</b>	
24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b> <b>6009 Harford Rd., Baltimore, Md. 21214</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

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20% COTTON FIBER  
OFFICE IN DOWNS

072463 NOV 1987

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 31066 EST

1. DECEASED NAME (TYPE OR PRINT) THOMAS ERNEST STAPLES			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 17, 1987			2b. HOUR 437 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 07 08 28		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY TOWING	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROMEY R. STAPLES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE V KELLUM		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SPECIAL OCCASION (IF YES, GIVE WAR OR DATES) 230 26 6994		17. INFORMANT Glen Burnie, Maryland 21061 Mildred J. Staples 212 Poplar Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver, Acute Renal Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>87</u> , to <u>11/17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. Karipineni</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/17/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RANI KARIPINENI, M.D.		22e. ADDRESS 200 HOSPITAL DRIVE, SUITE 300 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/21/87		23c. NAME OF CEMETERY OR CREMATORY Claybrook Baptist Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Weems Lancaster Va	
24. FUNERAL DIRECTOR NAME Raymond C. Fink				ADDRESS Glen Burnie, Md. 21061		25a. DATE REC'D. BY REGISTRAR NOV 18 1987	
						25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding pages 1 and 2 and should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		87		87		REG. NO. 31067EST	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THELMA R STEGER				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 25, 1987		2b. HOUR 236 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1926		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN Glen Burnie				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 415 Magnolia Rd. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Warren Rowley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lennie Trevillian			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-8997		17. INFORMANT ADDRESS Alton Steger, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart attack shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured Aorta Artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adrenal Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 8 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION 11/24/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aorta Artery		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 25</u> , 19 <u>87</u> , to <u>Nov 25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Nov 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Constantine I. Paduissis</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONSTANTINE I. PADUISSIS, M.D.				22e. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 30 Nov. 87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A., MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley, 421 Crain Hwy. S.E., Glen Burnie, MD 21061				25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE NOV 27 1987 <u>John Davidson</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be retained by the funeral home. Pages 1 and 2 should be retained by the funeral home for 72 hours after death. The funeral home should retain the original certificate and a copy of the certificate for 72 hours after death. The funeral home should retain the original certificate and a copy of the certificate for 72 hours after death. The funeral home should retain the original certificate and a copy of the certificate for 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A
		PATRICIA ANN STITCHER					11-02-87		1028 M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
F		CAU.		12 30 51		35			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
KY		USA				ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
FT. MEADE		KIMBROUGH ARMY HOSPITAL				HOUSEWIFE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MD		AA		FT. MEADE		13e. STREET ADDRESS / ZIP CODE 3032B BRANDT CT. 20755			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
HAROLD C. LOGSDON		MILDRED LOUISE MILLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		402-66-4195		DAVID A. STITCHER same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) HEMORRHAGING									
DUE TO, OR AS A CONSEQUENCE OF (c) STAGE IV CARCINOMA OF CERVIX									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2 NOV 19 87, to 2 NOV 19 87, that (I) (we) last saw the deceased alive on 2 NOV 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, 87)									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
DEBORAH J. MARTIN		MD						2 NOV 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
DEBORAH J. MARTIN									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		11/6/87		Howe Valley Cemetery		Cecelia		Ky.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hardesty Funeral Home, Annapolis, Md.				NOV 6 1987		Jesse Gordon-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card separators. Pages 1 & 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR 2. DECEASED NAME (TYPE OR PRINT) <b>Odessa P Surgeon</b>									
3. SEX <b>FEMALE</b> 4. RACE <b>BLACK</b> 5. DATE OF BIRTH <b>10 1 1951</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>									
9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>									
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b> 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b> 12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>ANNAPOLIS</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>21401 88 College Creek Terrace</b>									
14. FATHER'S NAME <b>JOHNNIE L. ROBINSON</b> 15. MOTHER'S MAIDEN NAME <b>EMMA PARKER</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO. <b>216-60-5274</b> 17. INFORMANT <b>Annapolis, MD. 21401</b> <b>TORRANCE DAVIS 88 College Creek Terrace</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Pericardial Effusion</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alcoholic Cardiomyopathy</b> <b>1 yr.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholism and Cirrhosis</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION      19b. CONDITION FOR WHICH OPERATION WAS PERFORMED      20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)      21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 30</b> , 19 <b>87</b> , to <b>Nov. 4</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 4</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22. SIGNATURE <b>Gary M. Richardson, M.D.</b> DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <b>Nov. 4, 1987</b>									
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY M. Richardson, M.D.</b> 22b. ADDRESS <b>104 Forbes Street, Annapolis, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>11-10-1987</b> 23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>									
24. FUNERAL DIRECTOR <b>Annapolis, Md. 21401</b> <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b> 25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1987</b> 25b. REGISTRAR'S SIGNATURE <b>G. Anderson-Randall</b>									

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 31070					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edwin E Taylor</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-28-87</b>				2b. HOUR <b>11:18 P</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 16 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD</b>			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TAVERN OWNER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>QUEEN ANNES</b>		13c. CITY OR TOWN <b>STEVENSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>321 SOUTH CAROLINA AVE. 21666</b>				14. FATHER'S NAME FIRST MIDDLE LAST <b>HORACE TAYLOR</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BELLE LEDFORD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>238-38-7303</b>		17. INFORMANT <b>EDMUND TAYLOR</b>		ADDRESS <b>7752 MIDDLEGATE CT. PASADENA, MD 21122</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>severe ischemic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/28 87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11/28 87</b>					
22a. I certify that (1) (this hospital) attended the deceased from <b>11/25 87</b> , to <b>11/28 87</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thomas Walsh MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS WALSH MD</b>				22e. ADDRESS <b>780 Ritchie Highway Severna Park Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>11-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS, INC</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATONSVILLE BALTIMORE MD</b>			
24. FUNERAL DIRECTOR NAME <b>McGully Funeral Homes</b>				24b. ADDRESS <b>3204 MOUNTAIN RD PASADENA, MD 21122</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>			

DEC 01 1985



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31071

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIE JOAN VEIRA THOMAS			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 29, 1987		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 14, 1935		6. AGE (IN YEARS (LAST BIRTHDAY)) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Pasadena	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home - 761 217th Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical	12b. KIND OF BUSINESS OR INDUSTRY C&P Telephone	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY A.A. Co.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 761 217th Street (21122)	
14. FATHER'S NAME FIRST MIDDLE LAST Wilfred E. Veira			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 32 7718		17. INFORMANT ADDRESS James Thomas same as 13 e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Carcinoma to the cerebellum</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> 19 <u>87</u> , to <u>11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Neil Padgett MD MPH</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Padgett MD			22e. ADDRESS 7706 Quarterfield Rd Glen Burnie MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11/30/87	23c. NAME OF CEMETERY OR CREMATORY Westview Mem Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME George J. Gonce 4001 Ritchie Hwy Balto. Md.			25a. DATE REC'D BY REGISTRAR NOV 30 1987		

1. The first part of the report is a general description of the project. It includes the title, the objectives, and the scope of the work. This section is intended to provide a brief overview of the project for those who are not familiar with it.

2. The second part of the report is a detailed description of the methodology used in the study. This section includes a description of the data sources, the data collection methods, and the data analysis methods. This section is intended to provide a detailed description of the methodology used in the study for those who are interested in the methodology.

3. The third part of the report is a description of the results of the study. This section includes a description of the data, the data analysis, and the conclusions. This section is intended to provide a detailed description of the results of the study for those who are interested in the results.

4. The fourth part of the report is a description of the conclusions of the study. This section includes a description of the conclusions, the limitations of the study, and the recommendations. This section is intended to provide a detailed description of the conclusions of the study for those who are interested in the conclusions.

5. The fifth part of the report is a description of the references. This section includes a list of the references used in the study. This section is intended to provide a detailed description of the references used in the study for those who are interested in the references.

6. The sixth part of the report is a description of the appendices. This section includes a list of the appendices used in the study. This section is intended to provide a detailed description of the appendices used in the study for those who are interested in the appendices.

7. The seventh part of the report is a description of the index. This section includes a list of the index used in the study. This section is intended to provide a detailed description of the index used in the study for those who are interested in the index.

8. The eighth part of the report is a description of the bibliography. This section includes a list of the bibliography used in the study. This section is intended to provide a detailed description of the bibliography used in the study for those who are interested in the bibliography.

9. The ninth part of the report is a description of the glossary. This section includes a list of the glossary used in the study. This section is intended to provide a detailed description of the glossary used in the study for those who are interested in the glossary.

10. The tenth part of the report is a description of the index. This section includes a list of the index used in the study. This section is intended to provide a detailed description of the index used in the study for those who are interested in the index.

11. The eleventh part of the report is a description of the appendices. This section includes a list of the appendices used in the study. This section is intended to provide a detailed description of the appendices used in the study for those who are interested in the appendices.

12. The twelfth part of the report is a description of the index. This section includes a list of the index used in the study. This section is intended to provide a detailed description of the index used in the study for those who are interested in the index.

13. The thirteenth part of the report is a description of the appendices. This section includes a list of the appendices used in the study. This section is intended to provide a detailed description of the appendices used in the study for those who are interested in the appendices.

14. The fourteenth part of the report is a description of the index. This section includes a list of the index used in the study. This section is intended to provide a detailed description of the index used in the study for those who are interested in the index.

15. The fifteenth part of the report is a description of the appendices. This section includes a list of the appendices used in the study. This section is intended to provide a detailed description of the appendices used in the study for those who are interested in the appendices.

16. The sixteenth part of the report is a description of the index. This section includes a list of the index used in the study. This section is intended to provide a detailed description of the index used in the study for those who are interested in the index.

17. The seventeenth part of the report is a description of the appendices. This section includes a list of the appendices used in the study. This section is intended to provide a detailed description of the appendices used in the study for those who are interested in the appendices.

18. The eighteenth part of the report is a description of the index. This section includes a list of the index used in the study. This section is intended to provide a detailed description of the index used in the study for those who are interested in the index.

19. The nineteenth part of the report is a description of the appendices. This section includes a list of the appendices used in the study. This section is intended to provide a detailed description of the appendices used in the study for those who are interested in the appendices.

20. The twentieth part of the report is a description of the index. This section includes a list of the index used in the study. This section is intended to provide a detailed description of the index used in the study for those who are interested in the index.

21. The twenty-first part of the report is a description of the appendices. This section includes a list of the appendices used in the study. This section is intended to provide a detailed description of the appendices used in the study for those who are interested in the appendices.

073798 DEC-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 31072  
REG. NO.

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) <b>Pearl</b>		FIRST <b>Alta</b>		MIDDLE <b>Thomas</b>		LAST <b>Thomas</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/25/87</b>		2b. HOUR <b>3:23</b>		MIN.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 18, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b>		7. UNDER 1 YEAR MONTHS DAYS <b>YES</b>		8. UNDER 24 HRS HOURS MIN. <b>YES</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b>		MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b>		MD		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		11. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
12. CITY OR TOWN OF DEATH <b>Edgewater</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Living Conv. Center</b>		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Maryland</b>		12b. COUNTY <b>P.G.</b>		12c. CITY OR TOWN <b>Hyattsville</b>		12d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		12e. STREET ADDRESS / ZIP CODE <b>2112 Charleston Place 20783</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Anderson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alta Peterson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) <b>No</b>		17. SOCIAL SECURITY NO. <b>219-48-4920-T</b>		18. INFORMANT (Son) <b>Robert J. Thomas</b>		ADDRESS <b>48 Chipouras Road</b>		CITY OR TOWN <b>Edgewater, Md.</b>		STATE <b>21037</b>	
19. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alzheimer's</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Robert J. Thomas</b>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7-9 11-25-87</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		20e. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1833 Forest Dr., Annapolis, Md. 21401</b>		20f. I certify that (I) (this hospital) attended the deceased from <b>7-9-87</b> to <b>11-25-87</b> that (I) (we) last saw the deceased alive on <b>11-25-87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death.		20g. SIGNATURE <b>Charles W. Kinzer</b>		20h. DATE SIGNED <b>11-25-87</b>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles W. Kinzer</b>		21b. ADDRESS <b>1833 Forest Dr., Annapolis, Md. 21401</b>		22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		22b. DATE <b>12/02/87</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>		22e. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, PA</b>		22f. ADDRESS <b>4739 Baltimore Avenue Hyattsville, Md. 20781</b>	

NOTION  
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1/1/10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 6731073

1. DECEASED NAME (TYPE OR PRINT) K HOUSTON CR <sup>d</sup> HUSTON THOMPSON						2a. DATE OF DEATH MONTH DAY YEAR 11 29 87						2b. HOUR 12:40 AM					
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 01 07 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		IF UNDER 24 HRS. HOURS MIN. 					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co MD.											
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Workman Boat Repairman				12b. KIND OF BUSINESS OR INDUSTRY 							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 90 Spa Road 21401					
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		14. FATHER'S NAME FIRST MIDDLE LAST Wilson Thompson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE COATES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.I		17. INFORMANT 218-14-3739		ADDRESS 90 Spa Road						Ethel Mae Werrells Thompson ANNA-MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ Cerebral artery thrombosis ischemic cerebral myofascia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months 2 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerosis																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11/28, 1987, to 11/29, 1987, that (I) (we) lost saw the deceased alive on 11/28, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE General Church								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/29/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gordon Church II								22e. ADDRESS 8 EVERGREEN ROAD SEVEN MD 21146									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-2-1987		23c. NAME OF CEMETERY OR CREMATORY Md NAT Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P.E. Md							
24. FUNERAL DIRECTOR NAME C.E. Hicks III								ADDRESS 1922 Forest Drive		25a. DATE REC'D. BY REGISTRAR DEC - 7 1987		25b. REGISTRAR'S SIGNATURE R. K. Anderson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**IMPORTANT:** If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified of one.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic injury, the medical examiner must be notified of onset.

**MEDICAL CERTIFICATION**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		8731074 REG. NO.									
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Margaret B Triggs								11 23 87			2:35 PM
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female		White		5 8 07		80 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Mass.		USA				ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Annapolis		ANNE ARUNDEL GEN.									
12. USUAL OCCUPATION (TYPE OF WORK FORM MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Management		Retired									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		Anne Arundel		Davidsonville				3720 Patuxent Manor Rd. 21035			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Peter W. Blunt				Catherine Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
N/A				018 28 8831		Hugh Triggs (Son) Same as 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Sepsis											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-10-87 to 11-23-87, that (I) (we) last saw the deceased alive on 11-23-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Robert T. Peterson MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				4-24-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Robert T. Peterson				25 Shaw St Annapolis Md							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		11/25/87		Gate of Heaven		S.S. Mont. Md.					
24. FUNERAL DIRECTOR (NAME AND ADDRESS)						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.						NOV 25 1987		J. L. Smith-Rudner			





072756 NOV 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31075

1. DECEASED NAME (TYPE OR PRINT) <b>James Tucker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 12 87</b>		2b. HOUR <b>745 AM</b>
3. SEX <b>Male</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 23 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Glen Bernie</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Arundel Geriatrics Nursing C.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Arundel</b>	13c. CITY OR TOWN <b>Glen Bernie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>7255 Furnace Brook Rd. 21061</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>? ? ?</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>? ? ?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-14-9322</b>		17. INFORMANT ADDRESS <b>Viola Boone 2412 Huron St. 21230</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA's Multiple</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>AS CVD</b> (b) <b>AS CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>AS CVD</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>① Flu ② Hypertension</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/10/87</b> to <b>11/12/87</b> , that (I) (we) lost saw the deceased alive on <b>11/10/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Elmo Gayoso</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elmo Gayoso, M.D.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/16/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landdowne Md.</b>		24. FUNERAL DIRECTOR NAME <b>Estep Bros. F.H.</b> ADDRESS <b>1300 Eutaw Place</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, check any injury, or other traumatic event, the medical examiner will be notified of this.

BP

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071794 NOV 13 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPHINE A. VENIZELOS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 05, 1987</b>			2b. HOUR <b>843 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 28, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>326 Magothy Rd. Severna Park MD 21146</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Aquilla</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa CENTINIO</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-10-2637</b>		17. INFORMANT ADDRESS <b>John Venizelos (Same as above # 13e)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypoxemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>pulmonary emphysema</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> , 19 <b>87</b> , to <b>11/5</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10/10</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James J. Benjamin</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/5/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES J. BENJAMIN</b>				22e. ADDRESS <b>653 OLD MILL ROAD MILLERSVILLE, MARYLAND 21108</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-9-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge MEM Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Howard MD</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>	
24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCO</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NUMBERED 02, 1967 413 A

JOSEPHINE A. WHITE VINTAGE

WINE ARMYNT COUNTY

NORTH ARMYNT HOSPITAL

GLEN BRIDE

633 OLD MILL ROAD  
MILLERSVILLE, MARYLAND 21108

JAMES J. BROWN

ROBERT S. BARRANCO  
SEVERNA PARK MD. 21146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
87 31077									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM VREDEVELT</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 4, 1987</b>			2b. HOUR <b>2 P</b> M	
3. SEX <b>Male</b>		4. RACE <b>Caucasion</b>		5. DATE OF BIRTH <b>OCT. 22, 1911</b> AR		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>418 Stanford Ct. Arnold MD 21012</b>	
14. FATHER'S NAME <b>Berend Vredevelt</b> MIDDLE LAST					15. MOTHER'S MAIDEN NAME <b>Siena Van Geest</b> MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>368-09-8910</b>		17. INFORMANT ADDRESS <b>Rose M. Vredevelt (Same as Above # 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Victor</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11-7-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD Veterans Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville, A.A. MD</b>			
24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCO</b>				25a. DATE REC'D BY REGISTRAR <b>NOV 12 1987</b> REGISTRAR'S SIGNATURE <b>J. J. Gaudin-Randall</b>					
25b. ADDRESS <b>SEVERNA PARK, MD. 21146</b>									

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Very respectfully,  
[Signature]

Very truly,  
[Signature]

ROBERT S. BARRARD  
SARATOGA PARK, N.Y. 12158

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EOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) Howard Ernest Wagner, Sr.			2a. DATE OF DEATH MONTH DAY YEAR November 8, 1987			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Severn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 939 Smith Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Correct. Officer	
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry E. Wagner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith V. Durm		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No NA			
16b. SOCIAL SECURITY NO. 218.12.8736		17. INFORMANT (Wife) ADDRESS Pauline C. Wagner Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intracranial Pressure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Protein Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several Months</u>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Remzi Demir</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/9/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Remzi Demir, M.D.		22e. ADDRESS 200 Hospital Drive Glen Burnie, Md. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 11, 1987		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Meade A A Co. Maryland	
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home</u> ADDRESS <u>Glen Burnie, Maryland</u>				25a. DATE REC'D. BY REGISTRAR NOV 10 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical certificate must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. A copy of this certificate must be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the coroner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
<div style="text-align: right;">87 31079 EST</div>											
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWARD ALBERT WALL</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 08, 1987</b>					2b. HOUR <b>2.15 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 3, 1913</b>			6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>74</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Wall</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel Barclay</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1929-1952</b>		17. INFORMANT ADDRESS <b>Goldie B. Wall, Same as 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/8/87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7/87</u> to <u>11/8/87</u> , that (I) (we) lost <u>11/7/87</u> above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Recep Erol M.D.</u>					DEGREE			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RECEP EROL, M.D.</b>					22e. ADDRESS <b>325 HOSPITAL DRIVE, SUITE 104 GLEN BURNIE, MARYLAND, 21061</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 10, 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie AA MD</b>			
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John Sebastian Radabaugh</i>				

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RECEIVED

ALBERT

MAIL

NOVEMBER 02, 1967

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ANN ARBOR COUNTY

NORTH ANNEBORO HOSPITAL

CLIN BUREAU

222 HOSPITAL DRIVE, SUITE 104

CLIN BUREAU, ANN ARBOR, MICHIGAN 48101

RECEIVED

072574 NOV 20 1987

FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31080

1 DECEASED NAME (TYPE OR PRINT) <i>Catherine E. WARD</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 18 87</i>			2b. HOUR <i>8:06</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 19 1886</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>100</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.			
10. CITY OR TOWN OF DEATH <i>Crownsville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fairfield Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Bookkeeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Auto Dr ship</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MD.</i> 13c. COUNTY <i>A.A.</i> 13d. CITY OR TOWN <i>Annapolis</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>680 Americanz Dr. 21403</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Henry Norwood</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Virginia Burr</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>212-14-2622</i>			17. INFORMANT ADDRESS <i>Evelyn E. Sites #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infection, malnutrition, Dehydration</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of the Vulva</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>mos</i> <i>1 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Profound Dementia; Multiple decubiti</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <i>1980</i> , 19____, to <i>Present</i> , 19____, that (I) <del>was</del> <i>was</i> <del>not</del> <i>not</i> <del>viewed</del> <i>viewed</i> the deceased alive on <i>9-24-87</i> , 19____, and that in (my) <del>own</del> <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) <del>not</del> <i>not</i> view the body after death.									
22a. SIGNATURE <i>Peter F. Verkauw</i>			DEGREE <i>ATTENDING PHYSICIAN</i>			MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-19-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PETER F. VERKAUW</i>			22e. ADDRESS <i>1833 Forest Dr. Annapolis Md 21401</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>11-21-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Annapolis A.A. MD.</i>		
24. FUNERAL DIRECTOR NAME <i>Taylor Funeral Chapel</i>			ADDRESS <i>Annapolis, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 19 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



073966 DEC 30

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 31081

1. DECEASED NAME (TYPE OR PRINT) <b>DAVID WEBSTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 20, 1987</b>			2b. HOUR <b>7:35</b> M			
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 2, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1305 Seabright Dr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cost Acct. U.S. Steel</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>St. Michaels</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Bozman Rd. 21663</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George William Webster</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eliza Crowther</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT <b>Doris J. Taylor</b>		1805 Seabright Dr. <b>Annapolis, Maryland 21401</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic cancer prostate</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>9 yrs</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>2-13</b> 19 <b>87</b> to <b>11-27</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10-28</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Cornelia M. Dettmer</b> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-23-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Cornelia M. Dettmer, M.D.</b>				22e. ADDRESS <b>1277 Green Holly Drive, Annapolis, MD 21401</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 23, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Michaels, Talbot Maryland</b>	
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24. FUNERAL DIRECTOR NAME <b>Sharon E. Leonard</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Dindon-Randall</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death and manner of death from the certificate and forward it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. The medical examiner may be notified of cause of death if item 21 is marked or item 18 shows any injury, or other traumatic event. The medical examiner may be notified of cause of death if item 21 is marked or item 18 shows any injury, or other traumatic event.

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705-179-6278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		87		31082		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LAWRENCE J. WELLS								11 14 87		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		BLACK		4 8 1923		64 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS		ANNE ARUNDEL GENERAL HOSPITAL									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE					
MARYLAND		A.A.		ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6 Neal Street 21401			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
WALTER		WELLS		HATTIE		PINDELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO				Annapolis, Md. 21401 ESTELLE WELLS 6 Neal Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>massive intracerebral bleed</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did / did not view the body after death.											
22b. SIGNATURE				DEGREE <i>MD</i> <i>COVERED</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Jacob E Teitelbaum				139 old Solomon St. Annapolis, Md 21401							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		11-19-1987		PINELAWN MEM. PARK		Annapolis A.A. Maryland					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR									
WILLIAM REESE & SONS MORTUARY, P.A.		NOV 23 1987									

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This document is to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Virginia Louise Westphal</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 15 1987</b>		2b. HOUR <b>7:05 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 26 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>A.A. Co.</b> 13c. CITY OR TOWN <b>Arnold</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>715 Hilltop Rd. Arnold 21012</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Seymour</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-10-2505</b>		17. INFORMANT ADDRESS <b>Walter Joseph Westphal (Same as Above)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital) attended the deceased from <b>11/15 1987</b> to <b>11/15 1987</b> , that (I) (we) last saw the deceased alive on <b>11/15 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Julia Davidson-Randall</b> DEGREE <b>MD</b>					22c. DATE SIGNED <b>11/15/87</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julia Davidson-Randall</b>	
22e. ADDRESS <b>495 Rockledge Hwy</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-19-19 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD Veterans Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville, A.A. MD</b>			
24. FUNERAL DIRECTOR NAME <b>Barranco &amp; Sons</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>				
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

87 31084

2a. DECEASED NAME (TYPE OR PRINT) <b>Mamie Weyer</b>			2b. DATE OF DEATH MONTH <b>11</b> DAY <b>16</b> YEAR <b>87</b> HOUR <b>6:50</b> M		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>24</b> YEAR <b>1896</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
10. CITY OR TOWN OF DEATH <b>Glen Burnee</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland Manor</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home Maker</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>243 Glenwood Road 21122</b>	
14. FATHER'S NAME FIRST <b>LEO</b> MIDDLE <b>Hoffman</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Fannie</b> MIDDLE <b>Bischoff</b> LAST <b>Bischoff</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-16-0398</b>		17. INFORMANT ADDRESS <b>Harold G. Sommer Same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>probable cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>probable pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>aspiration</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Recent cerebrovascular accident</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>11-16-87</b> to <b>11-16-87</b> , that (1) I saw the deceased alive on above, (1) I did not view the body after death.					
22b. SIGNATURE <b>Jerry D. Skarbek</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-16-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jerry D. SKARBEK</b>		22e. ADDRESS <b>3708 Mountain Rd Pasadena Md 21122</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/18.87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		23d. LOCATION Baltimore COUNTY <b>====</b> MD	
24. FUNERAL DIRECTOR <b>George J. Gonce 4001 Ritchie Hwy Baltimore Md</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>			
		25b. REGISTRAR'S SIGNATURE <b>Julia Pennington-Bond</b>			





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Female 17. Date 10-10-63

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071046 NOV-87

Item 13 per phone to  
 FOR STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

31086

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
LINDA		WHITE						2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female		BLK.		May 13 59		28		YRS.				10-28-87		MONTH		DAY		YEAR		11:50 pm	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7a. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Fairmount, Som. Md.		U.S.A.										Howard County								H.A.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Hanover, Md.		Southbound lane of US. Rt. 1 at S. Hanover Rd.		Hanover Rd.																	
13a. STATE		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		21871															
Md.		YES <input type="checkbox"/> NO <input type="checkbox"/>		Lower Hill																	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Gordy		Caselena																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No.				Shirley Worthing																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a):		Multiple injuries																			
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b):		DUE TO OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		11:16P 10-28-87		driver of an auto/vehicle collision													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FARM, ETC.)		21f. LOCATION		Southbound lane of U.S. Rt. 1 @ S. Hanover Rd.		Hanover County, Md.													
22a. I certify that I took charge of the remains described above, held on death, resulted from:		Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		10-29-87															
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		23f. STATE											
Burial		Nov. 1, 1987		Centennial		Fairmount		Som.		Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		NOV 4 1987		Julia Davidson-Randall													
Dennis F. Smyth		P.O. Box 119		Marion, Md.																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. AFTER DEATH, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))



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12 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES DOROTHY WHITEFORD</b>					2a. DATE OF DEATH MONTH <b>NOVEMBER</b> DAY <b>1</b> , YEAR <b>1987</b>					2b. HOUR <b>325</b> AM		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>APRIL</b> DAY <b>30</b> , YEAR <b>1920</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF HOME, STREET, CITY, AND STATE ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HMONEMAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>GLEN BURNIE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7 FERNDAL AVENUE 21061</b>				
14. FATHER'S NAME FIRST <b>FRANCIS</b> MIDDLE <b>K.</b> LAST <b>COLE</b>					15. MOTHER'S MAIDEN NAME FIRST <b>GRACE</b> MIDDLE <b></b> LAST <b>MITCHEL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NONE</b>		17. INFORMANT ADDRESS <b>300 Darlene Ave.</b> <b>CHARLES L. WHITEFORD, JR. (SON), Linthicum</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>smoking</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>chronic depression</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <u>2</u> 19 <u>87</u> to <u>10/31</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>10/31/87</u> 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>James I. Benjamin</u>					DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <u>10/1/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES I. BENJAMIN, M.D.</b>					22e. ADDRESS <b>653 OLD MILL ROAD MILLERSVILLE, MARYLAND 21108</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>NOV 4, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CEMETERY</b>			23d. LOCATION CITY OR TOWN <b>ELLICOTT CITY</b> COUNTY <b>MARYLAND</b> STATE <b></b>				
24. FUNERAL DIRECTOR NAME <u>AB Benson</u> ADDRESS <b>SINGLETON FUNERAL HOME, GLEN BURNIE MD.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 03 1987</b>			25b. REGISTRAR'S SIGNATURE <u>See Davidson-Randall</u>				

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Item 16a Filed 11/23/87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87

31088

1. DECEASED NAME (TYPE OR PRINT) William J. Whiteford			2a. DATE OF DEATH MONTH DAY YEAR November 16, 1987		2b. HOUR 6:30am
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 17, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Millersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 502 Moonflower Ct.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker		12b. KIND OF BUSINESS OR INDUSTRY Banking
13a. STATE Md.		13b. COUNTY A.A.	13c. CITY OR TOWN Millersville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John M. Whiteford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy E. Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES GIVE YEAR OF DATE) 1952-1954	17. INFORMANT ADDRESS Mrs. Patricia Whiteford (same as above)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cancer bladder, metastatic

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5 mo

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

Cancer bladder

DUE TO, OR AS A CONSEQUENCE OF

(c)

18 mo.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 23</u> , 19 <u>87</u> , to <u>Nov 16</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Nov 5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
22b. SIGNATURE <i>Cornelia M. Dettmer</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-17-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cornelia M. Dettmer, M.D., Ph.D.		22e. ADDRESS 1277 Green Holly Dr., Annapolis, MD 21401	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11-17-87	23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Westview A.A. Md.
24. FUNERAL DIRECTOR NAME ADDRESS <i>Jim</i> ROBERT S. BARRANCO SEVERNA PARK, MD. 21146		25a. DATE REC'D. BY REGISTRAR NOV 19 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Dettmer-Rudner</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 31089  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		Nov. 13 1987		9:45 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
M	N 2	MONTH DAY YEAR	77 YRS.	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
ANNAPOLIS	ANNE ARUNDEL GENERAL HOSPITAL				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	A.A.	ANNAPOLIS	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	966 Severdale Lane 21401	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST			FIRST MIDDLE LAST		
UNKNOWN			UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
NO			Annapolis, Md. 21403		
			LUCILLE HALL 695 Americana Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hour</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>A172 hemm shock</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> 19 <u>87</u> to <u>Permanently</u> 19 <u>    </u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>11/13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		DEGREE		22c. DATE SIGNED	
		M.D.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		11-18-1987		GREEN MOUNT CREMATORY	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS	
WILLIAM REESE & SONS MORTUARY, P.A.		Annapolis, Md. 21401		Baltimore, Md. 21201	

NOV 23 1987 REGISTRAR'S SIGNATURE

013033 101210



100 C. VUN

071405 NOV 10 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1090

1. DECEASED NAME (TYPE OR PRINT) <b>PAUL</b>		MIDDLE <b>N</b>		LAST <b>WILHIDE</b>		2a. DATE KNOWN OF DEATH ESTIMATED <b>11 2 1987</b>		2b. HOUR <b>1120</b>	
3. SEX <b>MALE</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>11</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 24 YR. MONTHS <b>0</b> DAYS <b>0</b>	8. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>11 2 1987</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNAPOLIS</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen.</b>				12. OCCUPATION (TYPE OF WORK) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Crownsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Box 502 21032</b>	
14. FATHER'S NAME FIRST <b>PAUL</b> MIDDLE <b>S.</b> LAST <b>WILHIDE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>LEAH</b> MIDDLE <b>DUBEL</b> LAST <b>DUBEL</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND GRADE) <b>YES W.W.II</b>					
16a. SOCIAL SECURITY NO. <b>578-22-2196</b>		17. INFORMANT NAME <b>PATRICIA BRANZELL</b> ADDRESS <b>8 FERNMAN ST ANNAPOLIS MD 21401</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>A.S.C.U.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Alcoholism, C.O.P.D.,</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET <b>695 America Ct.</b>		CITY OR TOWN <b>ANNAPOLIS</b>		COUNTY <b>AA</b>	STATE <b>MD</b>
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>William P. Jones, MD</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER				DATE SIGNED <b>11/2/87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, MD</b>		ADDRESS <b>695 America Ct. 21035</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-4-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Alexandria</b>				23d. LOCATION CITY OR TOWN <b>Fairfax</b> COUNTY <b>VA</b> STATE <b>Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Beall Evans Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM "B". GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

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(VR A15 ME (5))

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 31091 EST  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DOROTHY J WOLF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 24, 1987</b>		2b. HOUR <b>1235 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 18, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>PASADENA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY YOUNG</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOROTHY TOWNSEND</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>053 18 8723</b>	12. INFORMANT ADDRESS <b>CAROLYN BEUERLY (SAME AS 13A-E)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Lung Cancer</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 weeks</b> <b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>myocardial infarction</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23</b> 19 <b>87</b> to <b>11/24</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/23</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
27a. SIGNATURE <b>Lorraine M. Dailey MD</b>		DEGREE		22c. DATE SIGNED <b>11/24/87</b>	
27b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LORRAINE M. DAILEY, M.D.</b>		22e. ADDRESS <b>8667 FT. SMALLWOOD ROAD PASADENA, MARYLAND 21122</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>Nov. 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS, INC.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATONSVILLE BALTIMORE MD</b>
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **31093**

**1- FOR  
STATE  
REGISTRAR**

<b>2a. DATE KNOWN OF DEATH</b>		<b>2b. HOUR</b>	
MONTH DAY YEAR <b>11-18-87</b>		M <b>2:14P</b>	
<b>3. SEX</b>		<b>4. RACE</b>	
<b>MALE</b>		<b>WHITE</b>	
<b>5. DATE OF BIRTH</b>		<b>6. AGE (IN YEARS)</b>	
MONTH DAY YEAR <b>2 4 48</b>		LAST BIRTHDAY YRS <b>39</b>	
<b>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</b>		<b>7b. CITIZEN OF WHAT COUNTRY?</b>	
<b>MARYLAND</b>		<b>U.S.A.</b>	
<b>8. MARRIED</b>		<b>9. BALTIMORE CITY OR COUNTY OF DEATH</b>	
<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		<b>Anne Arundel County</b>	
<b>10. CITY OR TOWN OF DEATH</b>		<b>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION</b>	
<b>Glen Burnie</b>		<b>7428 B&amp;A Boulevard/Colonial Arms Gun Shop</b>	
<b>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</b>		<b>12b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>Parts Writer</b>		<b>Trucking</b>	
<b>13a. STATE</b>		<b>13b. CITY OR TOWN</b>	
<b>Maryland</b>		<b>Glen Burnie</b>	
<b>13c. INSIDE CITY LIMITS?</b>		<b>13d. STREET ADDRESS</b>	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<b>7503 Furance Branch Rd. Apt. F</b>	
<b>14. FATHER'S NAME</b>		<b>15. MOTHER'S MAIDEN NAME</b>	
FIRST MIDDLE LAST <b>David N. Wolle, Sr.</b>		FIRST MIDDLE LAST <b>Edith M. Kellum</b>	
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b>		<b>16b. SOCIAL SECURITY NO.</b>	
<input checked="" type="checkbox"/> YES, NO, OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		<b>212-52-5910</b>	
<b>17. INFORMANT</b>		<b>ADDRESS</b>	
<b>NO</b>		<b>Rosalee Reshneck 1213 Elmridge Ave. 21227</b>	

<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>
<b>PART I DEATH WAS CAUSED BY:</b>		
<b>IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u></b>		
<b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST:</b>		
<b>(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u></b>		
<b>(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u></b>		

<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</b>		
<b>19a. DATE OF OPERATION</b>	<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>	<b>20. AUTOPSY?</b>
		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<b>21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b>	<b>21b. TIME OF INJURY</b>	<b>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)</b>
	<b>2:10P.M. 11-18-87</b>	<b>subject shot</b>
<b>21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK</b>	<b>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)</b>	<b>21f. LOCATION</b>
	<b>gun store</b>	<b>7428 B&amp;A Blvd. Anne Arundel Co., Maryland</b>

<b>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b>		<b>DATE 11-19-87</b>
<b>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/></b>		
<b>ACTUAL SIGNATURE</b>	<b>TITLE (SPECIFY)</b>	<b>DATE SIGNED</b>
<i>Margarita A. Korell</i>	<b>M.D. Assistant MEDICAL EXAMINER</b>	<b>11-19-87</b>
<b>EXAMINER'S NAME (TYPE OR PRINT)</b>		<b>ADDRESS</b>
<b>Margarita A. Korell, M.D.</b>		<b>111 Penn Street</b>

<b>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>	<b>23b. DATE</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b>	<b>23d. LOCATION CITY OR TOWN</b>	<b>COUNTY</b>	<b>STATE</b>
<b>Burial</b>	<b>11/23/87</b>	<b>Loudon Park Cemetery</b>	<b>Baltimore</b>	<b>Maryland</b>	
<b>24. FUNERAL DIRECTOR</b>		<b>25a. DATE REC'D. BY REGISTRAR</b>	<b>25b. REGISTRAR'S SIGNATURE</b>		
<b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>		<b>NOV 20 1987</b>	<i>Julia Gordon-Rudner</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 2D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div>FOR STATE REGISTRAR</div> <div>1. DECEASED NAME (TYPE OR PRINT)</div> <div>Donald E. Wolfe, Sr.</div>									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. DATE OF DEATH	
Male		White		April 6, 1929		58 YRS		November 5, 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		2b. HOUR	
Baltimore, MD		USA				Anne Arundel County		6:07 A	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		7809 Overhill Road				Maintenance MECH.		Western Elec.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		AA		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7809 Overhill Road 21061	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Lawrence Wolfe				Marie K. Wolfe, Same as 13					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes				216-24-3246		Marie K. Wolfe, Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Pancreatic Ca</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-13-87</u> , 19 <u>87</u> , to <u>11-5-87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-23-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) saw the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<u>Paul Gourmley</u>		MD		11/5/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Paul Gourmley, M.D.				St. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		Nov. 7, 1987		Glen Haven Mem. Park		Glen Burnie		AA MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James S. Kirkley, Glen Burnie, MD				NOV 5 1987		<u>Julia Davidson-Randall</u>			

BP

1. The first part of the report  
describes the general situation  
of the country and the  
state of the economy.  
It also mentions the  
main problems which  
the government is facing.  
The second part of the report  
deals with the  
social and cultural  
aspects of the country.  
It describes the  
education system and  
the health services.  
The third part of the report  
deals with the  
foreign relations of the country.  
It mentions the  
main international  
organizations to which  
the country belongs.

2. The second part of the report  
deals with the  
social and cultural  
aspects of the country.  
It describes the  
education system and  
the health services.  
The third part of the report  
deals with the  
foreign relations of the country.  
It mentions the  
main international  
organizations to which  
the country belongs.

3. The third part of the report  
deals with the  
foreign relations of the country.  
It mentions the  
main international  
organizations to which  
the country belongs.  
The fourth part of the report  
deals with the  
conclusion of the report.  
It summarizes the  
main findings of the  
report and gives  
some recommendations.  
The fifth part of the report  
deals with the  
appendix of the report.  
It contains the  
list of the  
main sources of  
information used in  
the report.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

WILMER

ROBERT

WOODALL, SR.

7a. DATE OF DEATH

MONTH

DAY

YEAR

11

1

87

7b. HOUR

11:35A<sub>M</sub>

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

9

10

35

6. AGE (IN YEARS LAST BIRTHDAY)

52

YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

ANNE ARUNDEL COUNTY

MD.

10. CITY OR TOWN OF DEATH

HANOVER

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

7255 FOREST AVENUE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

ASSISTANT

12b. KIND OF BUSINESS OR INDUSTRY

TRUCKING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

A.A.

13c. CITY OR TOWN

HANOVER

13d. INSIDE CITY LIMITS?

YES ☐NO ☒

13e. STREET ADDRESS

7255 FOREST AVENUE 21076

14. FATHER'S NAME

Noble

MIDDLE

W.

LAST

Woodall

15. MOTHER'S MAIDEN NAME

Sushanna

MIDDLE

L.

LAST

Yingling

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

212-34-2790

17. INFORMANT

ADDRESS

21076

Joan Elizabeth Woodall 7255 Forest Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Scleroderma, systemic sclerosis*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

*Brnchogenic Carcinoma*

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M.

MONTH

DAY

YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from *May 3*, 19 *87*, to *Nov 1*, 19 *87*, that (I) (we) lastsaw the deceased alive on *Oct 24*, 19 *87*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

*11/2/87*

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. Joseph Miller

22e. ADDRESS

St. Agnes Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

11/4/87

23c. NAME OF CEMETERY OR CREMATORY

MEADOWRIDGE MEM. PK.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

ELK RIDGE

HOWARD

MARYLAND

24. FUNERAL DIRECTOR

NAME

HUBBARD FUNERAL HOME, INC.

ADDRESS

21229

4107 WILKENS AVE.

25a. DATE REC'D. BY REGISTRAR

NOV 06 1987

25b. REGISTRAR'S SIGNATURE

*John Gordon Ford*

71184 NOV-085

NOV 08 1985



BP

DHMH - 16 60M 7/84  
(VRS 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 7		REG. NO. 31095					
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR		A M	
MATTHEW		YOUNG II		11-23-87		0950		M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		Black		08 25 85		2 YRS		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
West Germany		USA				Anne Arundel MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
A.A., MD		Kimbrough Army Hosp		N/A					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE			
MD		AA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7223F Hall St/20755			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
MATTHEW		YOUNG		STEPHANIE YVONNE SHEPPARD					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
NO		N/A		MATTHEW YOUNG/FATHER					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGENITAL LARYNGEAL STENOSIS DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		22c DATE SIGNED					
JULIAN AUERBACH		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		23 NOV 23 1987					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
JULIAN AUERBACH		KIMBROUGH ARMY HOSP, FT. MEADE, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		11-27-87		Shady Grove Cem.		Tampa Fla.			
24 FUNERAL DIRECTOR NAME		25 DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Hardesty Funeral Home		NOV 30 1987		John Davidson-Randall					

073 36 11 10

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]*

NOTED BY 02/20/20

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 7 REG. NO. 3 1 0 9 6	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		7b. HOUR	
FIRST MIDDLE LAST Margaret M. Zacks		MONTH DAY YEAR 11 02 87		430 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	White	MONTH DAY YEAR Aug. 17, 1907		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Connecticut	USA			Anne Arundel MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	Anne Arundel General Hospital		Homemaker		Home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD	AA	Annapolis	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21401 213 Norwood Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Lawrence M. Moran		Sarah A. Malanophy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		045-16-4430		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/12/87 to 11/2/87, that (I) (we) lost saw the deceased alive on 6/12/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22c. DATE SIGNED		22e. ADDRESS	
22b. SIGNATURE Richard N. Peeler		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Richard N. Peeler, MD		51 Franklin St. Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (WHICH?)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	Nov. 9, 1987	East Side		Woodbridge New Haven CT	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Taylor Funeral Chapel - Annapolis, MD		NOV 5 1987		Julia Gordon-Randall	

1. 10/10/10

2. 10/10/10

3. 10/10/10

4. 10/10/10

5. 10/10/10

6. 10/10/10

7. 10/10/10

8. 10/10/10

9. 10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be verified at a coroner's inquest.

DHMH - 16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
072490 NOV 1987									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
VICTORIA ZELINSKAS					11 15 87		11:30A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		MONTH DAY YEAR 1 22 06		81 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
LINTHICUM		432 HILLVIEW DR.				HOMEMAKER			
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
MARYLAND					BALTIMORE		2804 WASHINGTON BLVD. 21230		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST GEORGE MASTAUSKAS					FIRST MIDDLE LAST ELIZABETH MILAUCKAS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					712-01-3284		GEORGE ZELINSKAS 432 HILLVIEW DR. 21090		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Adenocarcinoma</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Bronchiectasis, Obstructive Pulmonary disease, Atrial Fibrillation</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> 19 <u>87</u> , to <u>11/15</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive <u>above</u> (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. E. Johnson M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11-16-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Johnson					22e. ADDRESS 1001 Pine Heights Room 202				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			11/18/87		Most Holy Redeemer		Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hubbard Funeral Home, Inc. 4107 Wilken's Ave. 21229					NOV 18 1987		<u>Julia Davidson-Randall</u>		

MEDICAL CERTIFICATION

1. BIKER 001570

